S. HRG. 103–914

MEDICARE FRAUD: AN ABUSE

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

MIAMI, FLORIDA

APRIL 11, 1994

Serial No. 103–17

Printed for the use of the Special Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE

84–218 WASHINGTON : 1995

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-046588-5

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MEDICARE FRAUD: AN ABUSE

MONDAY, APRIL 11, 1994

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Miami, FL.

The committee met, pursuant to notice, at 9:30 a.m., at the Dade County Commission Chambers, 111 Northwest First Street, Miami, FL, Hon. Bob Graham (acting chairman of the committee) presiding.

Present: Senators Bob Graham and Larry Pressler.

OPENING STATEMENT OF SENATOR BOB GRAHAM, ACTING CHAIRMAN

Senator GRAHAM. I call the meeting to order. Welcome to this morning's hearing. This is a hearing of the Senate Special Committee on Aging. I express my appreciation to the chairman of the committee, Senator David Pryor, and the ranking member, Senator Bill Cohen, for their authorization to hold this field hearing in Miami today.

I would also like to thank my friend and colleague, Senator Larry Pressler of South Dakota, who has joined us for today's hearing. I would also like to thank the Dade County commissioners for allowing us to use this very beautiful and appropriate facility and thanks to their staff for the assistance that has been provided in organizing this meeting. And finally, I thank the witnesses who will be participating in today's hearing.

Medicare fraud is a serious and expensive problem for Americans. With annual expenditures in 1992 of approximately $131 billion, Medicare is the fastest-growing and the fourth-largest category of Federal spending, ranking only after defense, Social Security, and interest on the national debt. Medicare accounts for approximately 15 percent of all money spent in the United States on health care.

Medicare is a major program subject to major fraud. Experts estimate that fraud and abuse account for more than 10 percent of all Medicare and national health care spending. Between $10 and $20 billion is estimated to be lost annually.

South Florida is the right place to talk about this problem. There are 2.6 million Medicare beneficiaries in Florida; that is approximately 18 percent of the State's population. According to Blue Cross and Blue Shield of Florida, the administrator of Medicare for this State, approximately 52 percent of Medicare fraud in the State occurs in south Florida. Florida law enforcement authorities estimate that nearly $3 billion annually is siphoned off from the health

care system through fraudulent claims submitted to Medicare and Medicaid in this State. The growth of Medicare fraud in Florida and across the country not only undermines public confidence in the current health care system but also erodes confidence in the Federal Government's ability to carry out health care reform.

Many Americans question whether the issue of health care fraud and abuse will be addressed in an honest, open, and public way in the debate on health care reform. If we cannot eliminate fraud and abuse in our current health care system, how can we persuade the public that we can prevent fraud in our reformed system?

Today we want to speak openly and plainly about fraud. Of particular interest to us today are issues concerning the enforcement of existing policies and the prosecution of individuals who have victimized senior citizens through fraudulent Medicare activities. We will hear testimony from families and representatives of seniors who have been the subjects of fraud.

Our first witness will tell us how Medicare was billed $125 for 10 minutes of psychiatric treatment that her grandmother did not need. Our second witness will describe the "milk scam," where beneficiaries are sent a nutrition formula they do not need and often cannot drink. Our third witness will talk about misrepresentation in terms of Medicare billing.

On our second panel some of the many and various Federal agencies responsible for investigating and prosecuting fraud will discuss their problems in pursuing and investigating Medicare fraud. They will also comment on ways the Federal Government might better support their efforts to combat the problem of Medicare fraud.

Medicare fraud is widespread because it is easy to commit and easy to get away with. We have seen three major problems:

First, the methods used to commit Medicare fraud and abuse are difficult to detect. Some of those methods include—billing for services or supplies which are not provided; providing medically unnecessary services; altering billing codes to obtain higher payments.

The second problem that has led to random Medicare fraud is that resources allocated to combat fraud are inadequate. For example, the Office of the Regional Inspector General in Atlanta, GA, is responsible for the inspection of all Department of Health and Human Services [HHS], programs in eight Southeastern States. There are 300 different programs under the jurisdiction of HHS. Thirty-three agents and staff are assigned to cover these eight States, with 10 agents and 2 support staff assigned to Florida, with only 4 agents in the Miami area.

The third principal contributor to random Medicare fraud is the lack of coordination between Federal agencies and the programs they oversee. John Morris of the Florida Medicaid Fraud Unit will discuss how scam operations are run in both Medicare and Medicaid. Agencies need to work together to prevent scam artists from double dipping.

Seniors are not the only victims of Medicare fraud—taxpayers are victims as well. Fraud not only causes Medicare premiums and deductibles to rise; it increases the Federal deficit. As Congress tries to balance the budget, this issue will become increasingly important.

I look forward to today's hearing and today's witnesses. I am especially interested to hear suggestions about how the Federal Government can help stem the hemorrhaging of Federal dollars to unscrupulous scam artists.

We will ask each member of the panels to give first their oral statement. After each panel has completed their statements there will be a short question and answer period with questions from Senator Pressler and myself.

Again I want to thank each of you for your participation this morning. I would call on Senator Pressler for any statement that he would like to make.

STATEMENT OF SENATOR LARRY PRESSLER

Senator PRESSLER. Thank you, Senator Graham, and thank you for chairing this important hearing. I say it is an important hearing because we are in the beginning of a great national debate that really ranks with the great debates we have had in the Senate and House in history—it is over health care. Whether or not we adopt the Clinton health care plan or whether or not we adopt a bipartisan compromise, something very significant is going to happen in American history in the next 3 or 4 months regarding health care.

I say that this hearing is related to that for these reasons:

First, if there is, and there appears to be, widespread fraud, the American people, our taxpayers, want to know why. There are about 13 percent of my citizens in South Dakota, my home State, who collect Medicare, a smaller percentage than in Florida. Nevertheless I think across the Nation we are probably talking about an average of 12 and 13 percent. So the first question is people want to know why. Usually if you point at someone there are three fingers pointing at yourself. Maybe part of the problem is Congress. Maybe we have not responded appropriately to requests for more agents, although we have to look and see what the various administrations of both parties have requested. Maybe the administration has allocated funds in the wrong area. But something is seriously wrong, or maybe the system is wrong.

The second reason that this is very important is that with the Clinton health care plan, some will say: If we can't get fraud out of Medicare, won't this just increase the problem, the Chafee plan, or the Nicholas plan, or the Graham plan, or the Clinton plan? Whatever we are going to do, we are going to do something very significant one way or another in the next few months, so I hope, Mr. Chairman, that we are able to bring the results of this back in a brief report, a summarized report, that might be published by our committee, although I think the main thing we are going to do with the results here today is to bring it back to the debate we will be having in Congress.

I thank you very much because I think this is a timely hearing. I think it will deal with the national debate that we are holding in Washington, or about to start, so it will be doubly important. And I thank the witnesses.

Senator GRAHAM. Thank you very much, Senator.

I would like to introduce the three members of the first panel and ask if they would make their presentations in the order in which they are introduced. First, Ms. Sharon Rager of West Palm

Beach. Second, Ms. Luz Gual of North Fort Lauderdale. Third, Dr. Ariela Rodriguez of Miami, FL. If each of you would please make your statements, and then Senator Pressler and I will ask some questions.

Ms. Rager.

STATEMENT OF SHARON RAGER, WEST PALM BEACH, FL

Ms. RAGER. My grandmother is in a nursing home. She has limited vision, is extremely hard of hearing, and is sometimes unaware of her surroundings. Quite often she does not recognize her family members, even her daughter, who is at the nursing home twice a day. My grandmother is not mentally ill—she is old and the victim of many strokes.

One day a psychiatrist came to the nursing home and stopped in to say hello to my grandmother. Bingo. Medicare was billed $125. Keep in mind my grandmother would not know who he is. She would not understand any conversation unless he shouted in her ear. Two minutes after he left she wouldn't even know he had been there. Later, the psychiatrist began sending one of his associates in on a weekly basis. He would gather all of the residents into the activities room, and bingo, the physician would bill Medicare $55 for every person in that room. Neither my grandmother or the majority of the other residents could understand a conversation if they heard it.

My mother visits the nursing home every day. No one ever approached my mother to ask if she thought my grandmother could be helped by seeing a psychiatrist. It was all done behind my mother's back. She only found out what was going on after she got the Medicare explanation of benefits form. She immediately confronted the nurses at the home and told them that my grandmother was not to be seen again by the psychiatrist or taken into group therapy. The nurses did not send her in June, but started again in July. Again, my mother confronted them, so they did not take her in August, but started again in September. Finally, in October the therapy stopped, but only for my grandmother. The psychiatrist is still seeing the other residents on a weekly basis, and taking in the money from Medicare.

A woman who eats with my grandmother still has a good mind. She was told that the home was going to have someone come in on a regular basis to talk with the residents. She was told that it would not cost her anything. She thought the home was providing the service. Later, when she found out what was really going on, she was livid. She no longer goes to therapy and tells the other residents not to go either. Unfortunately, so many of the others are not as mentally alert as she is.

I reported this situation to the Medicare fraud division. Medicare found the doctor to be in error in my grandmother's case. Medicare has ordered him to repay all moneys paid to him for my grandmother's care. That's great, but it is not enough. He, along with others, are still robbing the American taxpayer.

This situation is not an isolated incident. I have phoned several nursing homes in this area. Every home that I have spoken to has regularly scheduled visits by psychiatrists. This policy needs to be changed overall.

Everyone is crying about health care waste, but we all continue to look the other way or take advantage ourselves. I feel if I do not speak up I will be as guilty as the psychiatrist. It has to stop. We can no longer let apathy and greed rob our Government.

And the bottom line total that he had billed Medicare in my grandmother's case was $950.

Senator GRAHAM. Thank you, Ms. Rager.

Ms. Gual.

STATEMENT OF LUZ GUAL, NORTH FORT LAUDERDALE, FL

Ms. GUAL. I appreciate this opportunity to testify here today on behalf of my mother, Mrs. Victoria Torres, and my aunt, Miss Isabel Pacheco. They are both elderly and they have had several experiences with Medicare fraud.

In 1992 my mother was at the food stamp office and a woman approached her. She claimed to be from the Government, and she asked her if she had any problems with her stomach. Although my mother said yes, she does not have any real problems except the regular discomforts of elderly people. The health care worker said that the Government was providing free milk for the elderly for Medicare beneficiaries. She said this would help them; whenever they feel like eating they can have this milk. She asked my mother for the Medicare card, and, of course, my mother gave it to her. She filled out a form and my mother signed it. She said she will be receiving a nutrition formula once a month. The man came in a rented van, and a U–Haul rented van. There were no signs on the van at all. It was just a white van. He delivered the milk. When my mother opened it she found out that this was not drinkable because it was very sweet and very thick, and she could not even take this formula.

So I wrote a letter and sometime later my mother received a notice from Medicare explaining that they had paid a Medicare claim for five cases of formula and 31 supply kits, and these were feeding kits. The total was like $737. I could not believe this, and I called Medicare and notified them of the problem. I have written several letters to Medicare since the lady approached my mother at the food stamp office.

With my aunt, unfortunately, she lives in Hialeah, and she fell prey of a Medicare scam involving a home health care company. In 1992 also, a woman visited her in a white nurse's uniform, and she asked her about her health. My aunt, of course, you know, let her in because she was dressed as a nurse. She asked my aunt for the Medicare card, took her blood pressure, and told her that the agency she worked for could send her groceries on a monthly basis, so my aunt did not have to walk to the store. My aunt agreed, and in November 1992 she received a bag of groceries, mostly products and all kinds of staples. In December, when all the elderly in the apartment complex received their groceries, then my aunt did not. So she called the office. She called the health care agency, and they told her that in order to receive these bags of groceries, she will have to have someone come to her house to clean the apartment on a monthly basis. My aunt is fully capable. She explained to the agency that she did not want anyone in her apartment cleaning; and, of course, she did not receive the groceries.

I reported the incident to the Medicare office and they sent a man to investigate. He said he was part of the team and asked my aunt to sign a paper saying that the nurse had visited her house. He explained to my aunt that if she signed the paper she would not have to pay any money from her pocket. When my aunt told me what happened, I was very upset, I was very furious, and I called the man. I asked him what kind of paper my aunt had signed. He was very defensive and told me he was an investigator, and he said that the paper she had signed was legal. I asked him to mail me a copy. He never mailed me a copy.

I have seen and heard of many ways to commit fraud against the Medicare Program. Some agencies send nurses to elderly homes and elderly offices, and they offer to pay them $50 if they agree to have a physical. The agencies will pick them up, drive them to the clinic. They will perform all kinds of tests and then they pay the patient, $50 and drive them back home. Some who see the psychiatrist get $75 cash. They get electric fans, regular shoes instead of orthopedic shoes, recliners, and the list goes on. There is another program where people get paid $25 cash on a monthly basis to keep a respirator in their home. Of course, they do not need it; it is just to keep it so they get $25. If they recommend someone, if they recruit other people, they get $10 for recruiting the person, and the person getting the respirator will get $10 or $15.

There are some clinics who hire nurses, so-called nurses with white uniforms. They visit the senior citizens' apartment complexes or where the elderly people are. If they recruit a person they get $125 cash for each patient they recruit. Of course, they do not have a need to go to the doctor; they just want the money.

I believe that operations are run by a very organized group. Something has to be done. Medicare money will be depleted due to fraud. Maybe even millions of dollars are going out of Medicare pockets right now into these people's pocket. The scams against Medicare and Medicaid are rampant. They are all over.

I would like to work in a position where I could help the elderly. The elderly many times feel that they—they feel harassed, they are afraid to fall, they are afraid to say what is going on. They do not want to come here, they do not want to be seen. I think they need somebody who can handle it.

Senator GRAHAM. Thank you, Ms. Gual.

Dr. Rodriguez.

STATEMENT OF ARIELA RODRIGUEZ, PH.D., A.C.S.W., MIAMI, FL

Dr. RODRIGUEZ. I am the director of health and social services for Little Havana Activities and Nutrition Centers of Dade County, Inc. We serve approximately 34,000 elderly persons per year. We have 16 comprehensive senior centers, 3 adult day care centers, and a staff of about 10 social workers.

Most of our work has to do with facilitating services for the elderly and for translating documents for them. Most of the people we serve are elderly immigrants that only speak Spanish. I can only echo what has been said here about Medicare fraud.

Every day most of our social workers' time is spent in trying to unravel these kinds of claims that come, the notifications that come

from Medicare stating that they have paid out this, that, and the other. It is unbelievable what is going on. It is like—I mean, you have said it all [turning to Ms. Rager and Ms. Gual].

I have brought persons that participate at the center who have been victims, and they are here ready to testify if you do so wish. One of the persons here went to a person to have her toe nails cut, and the next thing she knew she received a bill, a statement, from Medicare saying that somebody, an orthopedist had billed Medicare for over $2,000. What she had done was the cutting of her toe nails, but the Medicare number was used to bill for other things. Like that, we have a number of cases.

Another lady here, who is on our advisory council for Little Havana, her aunt, who had lived to 103 had been receiving physical therapy. It was months after she died that there was a statement saying that she had received physical therapy. The lady had been dead awhile.

What would help? I think that part of the problem is the idea that we have to prosecute these people to the point of declaring fraud. I would suggest that if we can do a few little changes in the way things are done, perhaps the point would be to stop them. The people that are prosecuted are the ones that have scammed $4 million off of Medicare. I would suggest to you that I would not allow them $4 million, I would stop them if I could much before $4 million are lost to fraud.

Some things work. We have been successful when these claims have come through and shows that there is an address or a phone number of the provider. We have called them, and we have said: We are reporting this to the Medicare programs. That, in some cases, has been sufficient for them to send a letter to Medicare stating that this claim was billed in error, so that stopped it right there.

However, there are some of these providers that do not have phone numbers, do not have addresses. They bill out of a post office box. I think that should not be allowed. I think that if you have a business, you identify the business by their business address and business phone number; and if you do not have one, then you are not allowed to bill Medicare. That would stop a few people.

We have pursued some business addresses and found ourselves in the middle of the warehouse district where such address does not exist. There are a number of things that can be done, not to prosecute so much, but to send the word out to cease and desist to these people. We, too, know about psychiatrists that operate so-called day treatment centers, and they bilk the persons of whatever they can. Then when their Medicare money is gone, they are out on the street, and they have to wait for another cycle to then bring them back in and do the same thing. While they are there, the victims are passed around from specialist to specialist, who are conveniently colocated with the psychiatrist and everybody takes their cut, and then they are let go once the Medicare money is exhausted.

The scams have no end. We were able to stop a scam, because one of our social workers who was providing services at a housing unit for seniors, one of the seniors brought her a piece of paper that was in English on one side and Spanish on the other. It was

an application to join the Medicaid/Medicare club. In this application you were offered cash, groceries, special shoes, transportation, whatever you wanted, and you would put it down on the piece of paper and you would sign it. Of course, one of the questions was: What is your Medicare number? We sent the application to the Alliance for Aging, Inc., here in Dade County and from there it went to the United Way, and it got out to every agency in town, and that scam was stopped right then.

So there are things that can be done, and we do not have to wait for the fraud branch to build a case to prosecute. They have to build a case. They have to take their time. We do not have the time. I do not want to wait. These are ways in which we can stop many of them early on, before the $4 million are taken.

[The prepared statement of Dr. Rodriguez follows:]

LITTLE
HAVANA
ACTIVITIES
& NUTRITION
CENTERS OF
DADE COUNTY
INC.

APRIL 11, 1994

U.S. SENATE SUBCOMMITTEE ON AGING

SENATOR BOB GRAHAM, FL, AND
CONGRESSMAN LARRY PRESSLER, SOUTH DAKOTA

HEARING ON MEDICARE FRAUD

WRITTEN TESTIMONY PRESENTED BY

ARIELA C. RODRIGUEZ, Ph.D., A.C.S.W.
DIRECTOR OF HEALTH AND SOCIAL SERVICES

Little Havana Activities and Nutrition Centers of Dade County, Inc. (LHANC) is a private not for profit (501 c 3) organization founded 21 years ago in response to the health, social and nutritional needs of low income, socially isolated, monolingual Hispanic elderly living in the South Florida area. From one activity center, LHANC grew with the needs of the elderly population and today LHANC serves more than 34,000 persons yearly at 17 comprehensive senior centers, three Adult Day Health Care Centers, two Intergenerational Child Care Centers, the Pro-Salud Primary Health Care facility, and its fully equipped Medivan.

Much of LHANC's health promotion, education and geriatric counseling effort addresses the need to educate our elderly participants to access available resources and to teach them how to protect themselves from false claims and fraudulent offers such as the many Medicare/Medicaid health fraud scams. Many of LHANC's participants have fallen victim to the "milk scam", the "bag of groceries scam", the "special shoes scam", and other scams where health professionals bill for expensive procedures that have never taken place, procedures such as cat scans, and surgery. In addition, relatives have brought to our attention claims for services allegedly rendered to persons who were deceased at the time of the service.

LHANC has accessed the Medicare Fraud Branch Outreach and Education Offices and presentations have been made in Spanish to

our participants on several occasions. LHANC's participants are at particularly high risk for becoming victims to the Medicare fraud scams due to the following conditions. Our participants do not read or write or understand English well enough to be able to discriminate between benefits allegedly offered by Medicare and those "gifts" used by scams to persuade the unwary elderly to divulge their Medicare number which is later used to defraud Medicare; our participants have great economic necessity, many live on the meager Supplemental Security Income and Food Stamps allotment so an offer of "free" groceries is eagerly accepted; our participants rarely have family that can protect or advocate for them when they have been victimized. Consequently, LHANC's Social Work Department spends an inordinate amount of time handling participants' Medicare statements that indicate that payment has been made on behalf of the participant for charges for health services that were never rendered. When a billing statement includes the telephone number of the service provider, a call is made to that provider informing him/her of the participant's report stating that the claim for health services is false and our intent to notify the Medicare Fraud Branch. Many times, as the result of this simple intervention, the health professional will withdraw the erroneous claim and the payment made in error is returned to Medicare.

As instructed by the Medicare Fraud Branch, fraudulent claims are reported via a phone call to the Medicare Fraud Hot Line 1-800-333-7586. Unfortunately, when the billing statements have only a P.O. Box for an address and no telephone number, LHANC's social workers find themselves reporting to the Medicare Hot Line the very same infraction over and over again for months. Naturally, the questions arise, What exactly is Medicare doing about stemming the tide of fraud? Does it make any difference to bother to report the blatant incidents of fraud perpetrated against the Medicare system when that system does not seem to be doing anything to stem the tide of fraud?

The word from the Medicare Fraud Branch is that they are "gathering information and building a case" to be able to prosecute the perpetrators. Periodically we read in the papers accounts detailing cases where Medicare finally nabs a perpetrator who, by the time an indictment is issued, has defrauded the Medicare system of 4 million dollars. Curiously too, Medicare has a formal Review and Appeal Process that allows health professionals to present documentation to permit the health professional to receive payment for claims that have been initially denied or paid at a

lower rate than expected. This review process is not available to the Medicare insured consumer.

Little Havana Activities and Nutrition Centers of Dade County, Inc.'s experience with our participants indicates that much can be achieved by intervening at the point of receiving the complaint about a fraudulent claim. This can be accomplished easily and inexpensively by instituting several simple administrative procedures. To this end, LHANC proposes that Medicare initiate the following three recommended changes as soon as possible:

1. Require and include in all billing statements the name, title, professional license number, business street address and telephone number of the health professional making the claim thus requiring that the licensed health professional acknowledge responsibility for the contents of the claim.

2. Designate someone at the Medicare Fraud Branch Telephone Hot Line to respond to any report of fraudulent claims by

    a. calling the health professional making the claim and question its accuracy, thus giving the health professional the opportunity to withdraw the claim,

and,

    b. if the health professional will not withdraw the questionable claim, then require and request documentation to support the claim in question.

3. Institute a formal Review and Appeal Process to hear the insured consumer's rebuttal to the claims presented by the health care professional. Unfortunately, LHANC's Social Work Department has uncovered claims where the insured consumer's signature has been forged on documents submitted to Medicare to support claims for payment of a false claim. Because documentation presented by perpetrators of Medicare fraud could be fraudulent too, the insured consumer deserves an opportunity to challenge the claims and documentation submitted by health care services providers.

A. Rodriguez PhD

Senator GRAHAM. Thank you, Dr. Rodriguez.

Ms. Gual, you were describing your relative who was involved with this milk scam. Had there been any indication that she needed this supplemental formula, that the kind of formula that was provided for her was appropriate to her condition?

Ms. GUAL. No. Like I said, my mother had just every now and then felt like maybe pains, you know, due to, I guess, you know, the age and maybe greasy foods. That is because we eat everything, almost everything, fried. But, no, she has no need to use this formula. The reason she fell for this is because she was at a food stamp office at the time, and the lady, of course, came to the office, inside the office, so she believed that she was part of the Government. She went and she said: Well, you know, maybe there is something I could take. And when it came, we opened it and I saw that it was very condensed, very sweet. Then I found out later on that there were tubes that people had to use.

Senator GRAHAM. She was not taking her food intravenously?

Ms. GUAL. Oh, no, no. No, she was not.

She was fine. She makes her own meals, because she can cook. She is fine. She has no problems.

Senator GRAHAM. A question to any of the members of the panel: When you discovered what you thought was fraudulent billing, how did you know who to contact, and what response did you get from the individual or entity that you contacted?

Dr. RODRIGUEZ. You call a number from the Medicare fraud branch. We reported it that way. What is frustrating about that is that we find ourselves with the same type of billing a couple months later and a couple of months later and a couple of months later and a couple of months later, and nothing has been done by Medicare to stop the fraud.

This is why I am saying we need to find ways in which we can stop people from doing this, short of prosecuting them. There must be—I am sure that if this were money out of your own pocket you would find ways of stopping the person from taking it. I am sure that the Internal Revenue System has systems and ways whereby they would have ways of handling things like this. And the money that is being spent on this is so great. It is not 2 cents.

Senator GRAHAM. Ms. Gual.

Ms. GUAL. In a way—I said that my mother told me what had happened—I was told this—and at home I found the Medicare office number. I actually mailed them a letter telling them that I wanted them to be aware of any bill and to send me a copy of anything they had been billed for, for my mother receiving this milk. And I think it came after awhile. They sent me a letter, I mean a statement, telling me what they have paid. The first bill that they paid, they have billed Medicare for $7,930.99. This was what they had delivered: they delivered 50 cases of their product, called Sistocal, which my mother could not use, and according to them, they said they were billing for the equipment, that we were getting equipment and everything else. So the first bill was $7,000. Then after that I sent another letter saying I was tired of writing that they are paying this after I have already told them what was going on. Then another bill came, and the second bill was for $737. Again I sent them another letter, and another bill came.

She stopped taking the deliveries because the Medicare office did tell me to tell them to stop, that's it, don't sign for anything. And she stopped receiving it, but they kept on billing Medicare. They billed to the point that the total bill was $7,930. They even billed for the months of August and September, when the hurricane—the house was no longer there, we had to move because of the hurricane. The house was destroyed.

The last correspondence I had from them was saying: We are investigating. It takes awhile. We will let you know. That was in 1993.

Senator GRAHAM. Ms. Gual, was there supposedly a physician who had prescribed this milk formula?

Ms. GUAL. I tried to find out. I did ask, and all they sent me was; they told me it was a nutrition company. I know of no physician. Of course, I think that you need to get a physician to prescribe that in order for them to expect Medicare to pay, because I am familiar with Medicare billing because I have worked in hospitals so I am familiar with Medicare billing and I know how careful most hospitals are about just billing for the right things, and you know only a certain amount is allowed. But what they did was they overbilled so they could get paid even enough, thousands of dollars even after they billed you.

Senator GRAHAM. Ms. Rager, how did you know who to contact when you became aware of what appeared to be a fraudulent situation?

Ms. RAGER. My mother had called the local Medicare office, and they really did not seem to care too much. They said, "Well, you are not paying for it," which made it all the worse.

Senator GRAHAM. Who was it that was that indifferent?

Ms. RAGER. The local Medicare office.

Senator GRAHAM. Was this an office of the Government or an office of one of the insurance companies that administered the program?

Ms. RAGER. I believe it was a Government office in our area.

So I called the Medicare fraud office, and I wrote letters to all my Senators and the Governor and the President. I just started writing letters to anybody, because I wanted to get to someone who could get to the bottom line and put a stop to it, because just solving this one particular case is great but it is not nearly enough, so I wanted to find out who actually set the policy. So I started writing letters. I asked the people at the Medicare Fraud Division. They were very helpful. I said: Well, who else can I write to who sets the policies? They gave me the address for—HCFA is the initial—so I corresponded with them.

Senator GRAHAM. What was your assessment of the responses, once you got past that first indifferent response? How effective were the followup mechanisms?

Ms. RAGER. It seemed to be pretty good. I was a little frustrated that it took longer than I thought, but, I can understand that they—Medicare Fraud Division—have to investigate and find out all the ins and outs about it. They kept in contact with me and representatives of your office and Tom Lewis' office would write to me regularly that they were still working on it.

After I got past the local level I was pretty satisfied. Then I was delighted when I heard that they ordered him to pay the money back.

Senator GRAHAM. Was he personally ordered to pay back, the psychiatrist?

Ms. RAGER. Yes.

Senator GRAHAM. Have each of you had any experience with State licensure boards, for instance?

[Witnesses indicate negative response.]

Senator GRAHAM. Were any of you contacted by any medical or hospital licensure board, inquiring as to the fraudulent situation that you had uncovered?

Ms. RAGER. No.

Ms. GUAL. I did try with my aunt, being that she had a temporary questionnaire asking her if she had black lung or any type of condition. I called the Medicare office. I tried to find out who the doctor was that diagnosed my aunt as being so ill, because at one point they had her like bedridden. A community nurse was coming to the house on a daily basis. They didn't give me the information, so I couldn't find out more, but that is what I was going to do.

Senator GRAHAM. Senator Pressler.

Senator PRESSLER. Yes; let me follow up with a few questions.

I think you are all very conscientious witnesses and courageous to come forward because a lot of this is probably just passed over most of the time.

Now, Ms. Rager, let me ask you what inspired you to report this? You are a conscientious person, I suppose. A lot of people just let it go would be the assumption, that it is usually just let go. That would be the assumption, that a lot of people probably do not care if their parent goes into a session or something if they are not paying for it. They would probably just ignore it. What inspired you to speak up?

Ms. RAGER. One of the things is, my mother relates to me all her frustrations, and she is at home every day and has seen so much going on. It just frustrates her so much and it is not good for her health.

Then I get frustrated, too, that, everybody just looks the other way, and I did not want to be a party to that. I felt like if I did not say anything, I am just as guilty as the home for letting it happen, the doctor going in there and billing Medicare, that I just did not want any part of it. I wanted to have my hands clean in the matter and do all that I could do.

Senator PRESSLER. I think that is a good point. I commend you.

Of course, after you have reported it two or three times you probably get frustrated, so, therefore, the Government or a company or the Medical Association or somebody should respond in a case like that. Maybe we need something like some administrative board that can act quickly on these things so people would not have to be prosecuted. It is such an extreme thing to get a prosecution going. Maybe we can send a special ombudsman, because we cannot be hiring policemen upon policemen if we call on that, but if you go to somebody where you could really get some action quickly. I think all of you found that it was tough to get action, didn't you, tough to get a response?

Yes? Go ahead, Dr. Rodriguez.

Dr. RODRIGUEZ. Medicare has in place a review process to benefit the providers of services. I would suggest that that process be looked at and made available on behalf of the beneficiary.

Senator PRESSLER. Yes. That would fall under case reviews, the review process.

Dr. RODRIGUEZ. What I am saying is the provider who wants more money on their claim or is appealing what they have been given in the way of payment, there is a process there in black and white written down, a review process, to assist them to get as much money as they can on their claim. There is no such process to assist the beneficiary to appeal their point of view, their claim.

Senator PRESSLER. A very good point.

Now, Ms. Gual, if you had not reported this billing fraud, nobody would have noticed for a long time and maybe there are a lot of these things happening. Would you assume if you had not reported it, the additional milk would have continued to be delivered?

Ms. GUAL. Yes; I believe so. In fact, it goes to show that they kept on billing after it was not delivered and was not coming. This is just one case. I know of millions of cases like that.

I was talking to a gentleman who just approached me, and he had the same situation of the billing made here for the same type of milk or nutrition drink and they will send him a bill paid by Medicare and they keep on billing. He tried to find the address and it was a storage place. He wrote to Senator Graham about it. He is sitting in the audience.

But I was moved to do this by my aunt and my mother, because when I worked for the Center in Aging, which was for a few months back in 1986 at the university, I saw that there was a need for a lot of research on the elderly, and I saw that there was a lot of elderly people that thought that they were gaining something, and they didn't, because they think that the Government has a full pocket and that the Government gives the money—some of them—so they don't worry about it. They don't think it is wrong because they are not charged by nurses and doctors or people who are in some professional capacity, so they think that they are not doing any wrong. I saw it at the time and I couldn't do anything about it, because nobody would come forward. This time I have my aunt and my mother and I am going to do something about it. That is why I am here.

Senator PRESSLER. These three cases, and I address this question to all three of you: These three cases would be blatant and they would be easy to understand, but I suppose there are a lot of other more sophisticated, on-the-margin cases, but in each case that has been brought here, there would have to be somewhere a doctor involved, although he might not know what is going on, and I believe most of our doctors are very honest but there would have to be a doctor in a major company, there would have to be some very sophisticated people involved somewhere; but I imagine if you looked at some of the more complicated, potential things that cannot be seen just when you walk into the nursing home, would you say that this is compounded very much? Would anyone want to comment on that?

Dr. RODRIGUEZ. I think that we have, we being today's computer-based technology to very easily flag Medicare bills for providers and for types of services and very easily come up with patterns of billings in areas where these billings are taking place and pinpoint what is going on and who is doing it and then see the numbers. I think that the computer-based technology is here. I think it could be done easily if somebody's heart were in it.

Little Havana, like I said before, we help over 34,000 elderly persons a year, who for the most part do not speak English. Many of these people not only do not speak English, they do not read English and they do not have family like these other persons did or do that could go and advocate for them, so they are really at the mercy of these people. These are people who are poor, and this is why they fall into the scams, the free groceries, the free shoes, the free transportation, because they are needy, so there is a need there. They are very easily hooked. They do not have extended families. Their families are either out of State or they live in the suburbs so they are living on their own. Many of them are living on their supplementary security income, which, as you know, is what, $400-something a month? With that they are supposed to pay rent and groceries and utilities and transportation, so they are looking for ways of surviving.

So they are at risk because of their poverty. They are at risk because they do not speak the language, they do not read the language. They are at risk because there is no extended family to advocate for them. So it falls on us, as professionals, to be there for them, but we are also asking that the professionals in the Medicare end of it help us, because it is easy to get discouraged.

The question, you know: Are they really doing anything?

That is the question.

Senator PRESSLER. What is the responsibility of the insurance companies in this area, or the provider companies? Do they catch this?

Dr. RODRIGUEZ. I would say that if there is a review process opportunity where a person, the same way we now call in the Medicare Program, and make our report of fraud, if we could instead, call in to request a review process, to discuss the claim with an administrative officer.

Senator PRESSLER. An individual who is empowered as ombudsman? The reason I am asking this question, because we need to learn lessons from meetings like this, but what lesson can be learned for the Clinton health care plan or for the Chafee health care plan, or whatever is adopted up in Washington?

Dr. RODRIGUEZ. My opinion is that we cannot wait for the fraud to be provable in court. We have to have something in place where anything that is suspicious and any complaint raised by a beneficiary is listened to seriously and taken care of right then and there, like we do. At our offices we attempt to contact the person, the providers, to verify that the claim is not a mistake, so that they have the opportunity to withdraw the claim.

What I am saying is, I would hope that that kind of a—maybe even a mediator, some kind of an administrative officer, not an ombudsman, somebody with authority that can question the billing

before it is paid. It has to be stopped before it is paid and it can be stopped before.

Senator PRESSLER. Thank you very much; Mr. Chairman.

Senator GRAHAM. Just a couple more questions, Ms. Gual.

Did you indicate that your relative was contacted by a scam artist at a Government facility or were you?

Ms. GUAL. My mother, yes.

Senator GRAHAM. Was contacted at a food stamp office?

Ms. GUAL. Yes.

Senator GRAHAM. From your experience, is that a prevalent practice, to——

Ms. GUAL. Absolutely. Absolutely.

Senator GRAHAM. Do you have any recommendations? What might Government offices do to protect themselves against being used in this way as the convenient pickup point for scam artists?

Ms. GUAL. I believe that the only people that should be allowed there are the people who work there and the people that go there for services. They should not have tables set up with people being at the tables, tables for clinics or for the nutrition center like this one. These people should not be allowed to be in that office. They should not be allowed to be outside of the door. I walk and I see people with a little pad and then they ask: Do you have Medicare?

They ask the people right in the street: Do you have Medicare? Do you have Medicaid? They say yes, and they have something to offer.

I do not think this should be allowed. You cannot control the streets, but you can control the offices, the Government offices, county, Federal. All these offices, the only people that should be there are the people that work there and the ones that go there to request the services.

Dr. RODRIGUEZ. The same goes for senior centers. We do not permit anybody who has not presented their credentials to us formally to have access to speak to anybody at the senior centers.

The participants have their ID. They know who they are. We know who they are. Anybody that does not belong there is not allowed there unless they have presented their credentials formally to one of the professional staff there.

Senator GRAHAM. Dr. Rodriguez, while this hearing is focused on Medicare fraud, there are a number of other Government-assisted health care programs, Medicaid and programs for current and retired members of the military, Veterans Administration, et cetera.

Have you encountered in your experience at the senior center other instances of fraud directed at these beyond Medicare health care programs?

Dr. RODRIGUEZ. Not in our experience. No.

Ms. GUAL. I have.

With Medicaid they have a doctor. The person goes to this doctor, who—of course, gives them prescriptions for drugs that they do not need. They take the prescription to the pharmacist, specific pharmacist. The pharmacist gives them a voucher for money. They could accumulate as many vouchers as they want, and at the end of the year they could buy Christmas presents, they could buy anything they want from the pharmacy. This has been going on for many years. Because I found out about this, I believe it was, in

1985 or 1986 when I was working in the center and I was going to the houses, the homes of people. I was really amazed.

I know one of the doctors that was part of that was prosecuted and I think he can no longer practice medicine. But that was one doctor, and there are many.

Senator GRAHAM. I share the comments made earlier by Senator Pressler of appreciation and admiration for your willingness to participate in this hearing today.

We are now going to hear from our second panel, who represent various agencies with enforcement responsibility. I would, if you would be able to do so, invite you to stay, and when they complete their testimony we might have some dialog between you and the enforcement agencies to pursue further the specifics of your individual cases.

Again, I thank you very much for your extremely helpful participation this morning.

Our second panel has four representatives of various enforcement agencies. First, the U.S. attorney for the Southern District of Florida, Mr. Kendall Coffey. Second will be representing the Office of Inspector General, Department of Health and Human Services, Mr. Al Hallmark, who is the regional inspector general in Atlanta, GA. Third, representing the Federal Bureau of Investigation, Mr. George B. Clow III, Special Agent in charge of the Miami Division. Fourth, Mr. John Morris, Director of the Florida Medicaid Fraud Unit in Tallahassee.

Mr. Coffey.

STATEMENT OF KENDALL COFFEY, U.S. ATTORNEY, SOUTHERN DISTRICT OF FLORIDA, MIAMI, FL

Mr. COFFEY. Thank you very much, Senator Graham.

Let me begin on behalf of the Federal law enforcement community of south Florida to express our appreciation to you, Senator Graham, and to you, Senator Pressler, for being here. It is obvious that the problem in south Florida with these conditions is enormous, and the kind of leadership that you are showing, the kind of commitment that you know to follow really have an important potential to make a very, very big difference.

Florida is home to 2½ million Medicare beneficiaries. Nearly 2 million Floridians receive Medicaid benefits. As you know, approximately 13 billion Medicare benefit dollars and over 4 billion Medicaid benefit dollars are spent in Florida each year.

According to GAO, up to 10 percent of all national health care expenditures are lost to fraud. Just applying that analysis alone, not looking at any of the other factors that specifically implicate south Florida, you would estimate that close to $2 billion of Medicare and Medicaid spending in Florida would be wasted on payments for fraudulent health care practices.

The fraudulent schemes range from offering the elderly certain equipment, such as hospital beds or devices to help them breath when they have colds, or food products such as cheese or milk supplements—for free—while claiming that Medicare or Medicaid will pay for them. You have already heard some very telling specifics about some of the milk schemes. There are many others, and there is no limit on the variations.

Distributors will need only to ask for the person's Medicare number, which the companies and clinics bill for medically unnecessary and nondelivered services and products. For many of the perpetrators of health care fraud receiving that Medicare number is like getting a license to steal.

Or laboratories will bill for unnecessary tests or tests not performed. Or companies go around to nursing homes and senior citizen congregate living facilities and provide expensive incontinence kits, when only diapers are needed, and, of course, Medicare and Medicaid get billed for it. Or opticians provide single lens glasses after cataract surgery and then bill Medicare for trifocals and bifocals. Or companies transport beneficiaries to clinics where doctors sign fraudulent prescriptions for conditions requiring home health care and then provide housecleaning services for months, switch the beneficiary to another company to do the same for months, and all the time billing Medicare and Medicaid for home health care services that are not provided. Many of these companies go into business to defraud the Government, and, after they collect money for a year or two, they shut down and start up again under a new name.

The claims processing system cannot very well defend itself against these fraudulent operators; it cannot readily identify and deny payments for fraudulent claims. As long as that is true, it will be very difficult for us to stay ahead of those who are in business to submit fraudulent claims. We have to be smart and fast and thorough to catch any significant number of them. Our objective is to try to see that justice is done while they are still in business to get a better chance of getting back to the public some of the money that was stolen.

The beneficiaries help us by reading their notice of Medicare benefits paid out in their name. Insiders help by coming to tell us about fraudulent claims.

We have committed this office to providing the resources to begin to make it too risky for these defrauders to engage in this type of fraudulent behavior from a criminal prosecution and treble damages point of view.

There are a number of other agencies that are very, very actively involved in this challenge. Obviously the Federal Bureau of Investigation has an outstanding squad and a major commitment. The HHSIT's office is a very significant player. FDA, Postal Service, EPA, Drug Diversion Unit, and, of course, the State Medicare fraud control unit, Department of Insurance, even IRS had roles to play.

Still there is much, much more help that is needed in terms of investigative agency resources if we are to begin to make enough of an impact to make enough of a difference.

We seem to build upon existing efforts through the South Florida health care fraud task force, in which Federal and State investigative agencies and assistant U.S. attorneys from our criminal and civil divisions meet on a regular basis to mount a united attack. We have assigned extremely experienced criminal and civil assistant U.S. attorneys to work on these cases.

We are proud of the fact that we led the Nation in criminal indictments last year, and we are trying to beat our own record this

year. And we have placed a new emphasis on civil recoveries and made it a priority of our civil division.

I would like to emphasize that we believe strongly that a very significant number of these defrauders must be pursued civilly. It is important and we will continue to bring criminal prosecutions and to seek the maximum sentences prescribed by law. But the billions of health care dollars that are spent on fraudulent claims must in some way be recaptured.

We have thus put new emphasis on civil prosecutions and hope to recover substantial moneys.

There are a number of issues that need to be addressed, and they are all grave and have been well-articulated this morning. There are two that I would share with you as part of the overall need for greater allocation of investigative resources to south Florida—one, we would speak specifically to the need for Health and Human Services agents. They are experts in this area, and they do civil and criminal investigations with great effectiveness. Adequate resources are needed. I would encourage the agency to relocate agents from areas which are not seeing the type of aggressive, massive fraud occurring in south Florida. We have only 4 agents now and we need at least 15.

Second, the President's Health Security Act provides that material gathered in grand jury investigations can be shared with our civil assistant U.S. attorneys. This statutory bill is not included in all of the health care reforms. We need it if we are going to be successful in grabbing the assets and funds of the defrauders to get back the Government's money. This provision is part of the bank fraud statutes.

I know it might seem like a somewhat technical point. It is extremely important that civil prosecutors be able to work with criminal prosecutors hand in hand in order to determine which cases ought to be brought civilly. That feature of the President's crime bill is quite important.

Even though my statement focuses on Medicare and Medicaid fraud, you should be aware that health care fraud in the private insurance sector is as widespread, perhaps even more so.

Thank you for your time, Senators. Please let me know if there is anything further that we can do to contribute to the objectives. Again I am speaking for all of south Florida law enforcement. We greatly appreciate your being here.

Senator GRAHAM. Thank you, Mr. Coffey.

I want to also thank you for being so aggressive in highlighting this issue. I know that you have been in contact with Tom Nicholas in the Department of Justice, as well as in HHS, in bringing his attention aggressively to their personal attention.

We hope that, plus what we are doing today, and our continued efforts will get the desired response.

Mr. Al Hallmark, regional inspector general, Department of HHS.

STATEMENT OF AL HALLMARK, OFFICE OF THE INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ATLANTA, GA

Mr. HALLMARK. Senator Graham and Senator Pressler, the OIG also welcomes these hearings. It will help to focus attention on the most needed area of Medicare fraud abuse.

As you are aware, it is costing this Nation billions of dollars every year, but it is not just the billions of dollars. In many instances it is also putting citizens at risk because it exposes them to unnecessary tests, procedures, or equipment—equipment that may be dangerous to those citizens.

As the principal agency responsible for health care in the United States we have two large programs, Medicare and Medicaid. Those two budgets now exceed that of the Department of Defense.

Here in south Florida we are aggressively pursuing health care fraud. We are using three enforcement authorities—both criminal prosecution, civil prosecution, and administrative sanctions. In 1993 when we excluded 70 health care practitioners here in Florida, we recovered $13 million in CMP cases here in Florida. These CMP cases and recovery——

Senator GRAHAM. Mr. Hallmark, please. CMP?

Mr. HALLMARK. Civil monetary penalties. It is an administrative law that we use on fraud cases.

Nationwide we are bringing back $61 for every $1 that is invested in our organization. I think that because of the value that we bring and the experience that we bring to investigations that HHS should be able to contribute heavily to this important area.

Because of the limited time we have today, I have selected just a few examples of the fraudulent abuse and practices we have seen.

We had a psychiatrist that had to repay over $300,000 to Medicare for submitting claims that meant he was working more than 24 hours a day.

We have unlicensed physicians that are billing under clinics and under licensed physicians' provider numbers, costing millions of dollars.

We had an ophthalmology group that repaid us $2½ million to resolve claims arising out of two billing schemes that did not rise to the level that we were able to use the criminal prosecution remedy.

We had a case in Georgia involving $2½ million, where a chiropractor was paying patients to come to his office so that he could bill. He was treating supposedly 169 patients a day.

This is not just in south Florida though. This is a problem nationwide. A part of the problem is the lack of resources that are available to identify the waste and to combat the fraud that is in the program.

And why is health care the target of fraud and abuse? I think it is because, as I said earlier, there is $300,000 billion out there. The criminal element will go where the dollars are.

To enhance our resources we support the establishment of the All-Payer Health Care Fraud and Abuse Control Account. I believe that that is included in President Clinton's plan, as well as a number of other plans that are currently before Congress. Funds for

this account should include both Federal criminal, civil, and administrative penalties.

In addition it is critical that we coordinate our efforts in the health care program. There are numerous Federal, State, and local law enforcement groups with a stake in investigating and prosecuting health care problems. We work closely with the FBI and other Federal agencies and the State Medicaid Program.

We welcome hearings such as this which will help draw attention to the Florida problem.

As Congress and the Nation contemplate changes in the health care system, we believe the problem of fraud and abuse has to be addressed. That is quite obvious.

This concludes my direct testimony. Any questions?

[The prepared statement of Mr. Hallmark follows:]

TESTIMONY

OF

ALBERT A. HALLMARK

REGIONAL INSPECTOR GENERAL

OFFICE OF INSPECTOR GENERAL

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Good morning Mr Chairman and members of the committee. I am Albert Hallmark, Regional Inspector General for the Office of Inspector General of Department of Health and Human Services (HHS). I am pleased to be here today to discuss the important issue of Medicare fraud and abuse. As you are aware, health care fraud, abuse, and waste are major problems that cost our nation's health care system billions of dollars each year. In addition, they put citizens at risk by exposing them to unnecessary or substandard medical tests, procedures, or equipment.

INTRODUCTION

The Department of Health and Human Services (HHS) is the Federal Government's principal agency for promoting the health and welfare of Americans and providing essential services to persons of every age group. The Department's two largest health programs are the Medicare and Medicaid programs, which are administered by the Health Care Financing Administration (HCFA). Medicare provides health insurance coverage to approximately 36 million beneficiaries aged 65 and older and to certain disabled individuals. The Medicaid program provides grants to States for the medical care of approximately 35 million low-income people. Expenditures for the Medicare program will total about $158 billion this year and expenditures for Medicaid will reach approximately $150 billion ($87 billion Federal share). In the State of Florida, Medicare provides coverage to 2,454,193 beneficiaries and the Medicare expenditures will total over $10 billion ($10,361,327,000). The Medicaid program will extend medical care to 1,803,410 low-income Florida residents at a cost of $4,071,960,159 ($2,234,095,281 Federal Share).

Created in 1976, the Office of Inspector General (OIG) is statutorily charged to protect the integrity of departmental programs, as well as promote their economy, efficiency and effectiveness. We meet our challenge through a comprehensive program of audits, program evaluations, and investigations.

The activities of our office consist of a multi-faceted approach to improving the management of the Department's programs and protecting the beneficiaries from fraud, waste, and abuse. Over the years, the Medicare program has seen significant reforms, some of which resulted from issues brought to light by the OIG. Such reforms include implementation of a prospective payment system (PPS) for inpatient hospital services and a fee schedule for physician services, the Clinical Laboratory Improvement Amendments of 1988, regional consolidation of claims processing for durable medical equipment (DME), establishment of fraud units at Medicare contractors, prohibition on Medicare payment for physician self-referrals, and new payment methodologies for graduate medical education.

We are also very active in analyzing the cost-effectiveness of services delivered. Over the years, we have documented excessive payments with respect to hospital services, indirect medical education payments, durable medical equipment, and laboratory services. In many cases, our recommendations have lead to statutory changes to reduce payments in these areas. Through these activities, we have sought to ensure that program dollars are spent without undue waste and that the financial viability of the trust funds is maintained.

We are equally concerned that the beneficiaries of our programs receive high quality care. Over the years, the OIG has assessed clinical and physiological laboratories, medical necessity of certain services and medical equipment, and various State licensure and discipline issues. We have also reviewed several aspects of medical necessity and quality of care under the prospective payment system, including the risk of early discharge. Finally, we looked at the quality of care provided by itinerant surgeons, and surgery provided in physician's offices.

We also evaluate the adequacy of internal controls that are both in place and planned to prevent losses to fraud, waste, and abuse. We carry out these evaluations by playing an active role in the Department's Federal Manager's Financial Integrity Act (FMFIA) program which detects and corrects systemic weaknesses, reviewing internal controls as part of our audits of the financial statements issued under the Chief Financial Officer's Act of 1988, and working with HCFA in planning, development, and implementation of new claims processing and management information systems to help assure adequacy of program safeguards on a national basis.

Our investigative role is aimed at reducing and preventing fraud and abuse and ensuring that beneficiaries receive high quality care at appropriate payment levels. We utilize three enforcement authorities: (1) criminal prosecution, (2) civil prosecution, and (3) administrative sanctions (which include both program exclusions and civil monetary penalties). All investigations can result in one or more of these remedies being employed. We refer investigative findings directly to the United States Attorneys for possible criminal or civil prosecution. Once the Department of Justice has completed or

declined a criminal or civil prosecution, HHS can impose civil monetary penalties pursuant to the Civil Monetary Penalties Law, 42 U.S.C. 1320a-7a. The OIG is also responsible for implementing the Secretary's authority to exclude fraudulent or abusive providers from participation in Federal health care financing programs. Our authorities are described in more detail below.

Criminal Authorities -- Federal prosecutors seek to redress heath care fraud by using traditional criminal authorities, including mail and wire fraud statutes, the False Claims Act, and false statements statutes. Congress also has enacted criminal statutes directed specifically to prevent fraud and abuse within Federal health care programs. Such authorities include criminal penalties for false claims and statements specifically involving the Medicare and Medicaid programs, and the Medicare and Medicaid anti-kickback statute. The anti-kickback statute prohibits an individual or entity from offering, paying, soliciting, or receiving remuneration with the intent to induce Medicare or Medicaid program business or in return for the referral of this business.

Civil Authorities -- Federal prosecutors also rely on civil authorities to combat health care fraud and abuse. Foremost is the civil provisions of the False Claims Act which authorize the Federal Government to recover treble damages, costs, and a civil penalty of between $5,000 and $10,000 for each false claim.

Administrative Sanctions -- The Department enforces two types of administrative sanctions in the Medicare and Medicaid programs: civil monetary penalties (CMPs) and program exclusions. In 1981, Congress authorized HHS to impose CMPs, assessments, and program exclusions on individuals and entities who submit false or improper claims for Medicare or Medicaid reimbursement. Since the first CMP was enacted in 1981, Congress has greatly expanded this authority. HHS has had the authority to exclude from participation in Medicare and Medicaid any health care providers and practitioners determined to have engaged in fraudulent or abusive practices since 1972. The Medicare and Medicaid Patient and Program Protection Act (Public Law 100-93) provides a wide range of authorities to exclude individuals and entities from the Medicare, Medicaid, Maternal and Child Health, and Block Grants to States for Social Services programs. Exclusions can be imposed for conviction of fraud against a private health insurer, obstruction of an investigation, and controlled substance abuse, as well as for revocation or surrender of a health care license. Exclusion is mandatory for those convicted of program-related crimes or patient abuse.

The number of sanctions and civil monetary cases we have resolved has increased significantly in recent years. The number of providers and practitioners excluded from program participation increased from 230 in FY 1983 to 881 in FY 1993. In FY 1993 the OIG excluded 70 health care providers/practitioners from program participation in the State of Florida. Six CMP cases were resolved by the OIG in FY 1983 resulting in recoveries of $1.4 million, while the 75 cases resolved in FY 1993 resulted in recoveries of $140 million. Over $13 million ($13,079,078) were recovered from Florida CMP cases. Successful health care prosecutions in the criminal courts have also dramatically increased, from 30 in 1982 to 181 in FY 1993. Overall, the Office generated savings, fines, restitutions, penalties, and receivables of over $61 for each Federal dollar invested in its operation.

EXTENT AND TYPES OF HEALTH CARE FRAUD AND ABUSE

Recently, the rapid rise in health care expenditures and problems associated with access have attracted unprecedented attention and scrutiny. This attention has also brought about discussions regarding the magnitude and pervasiveness of fraud, waste, and abuse.

In examining monetary losses to health programs, some distinction should be made among fraud, abuse, and waste. Although frequently one problem or failing involves all three, we use the following rough definitions.

- **Fraud** is the obtaining of something of value through intentional misrepresentation or concealment of material facts.
- **Abuse** is any practice that is not consistent with the purposes of providing patients with services which (1) are medically necessary, (2) meet professionally recognized standards, and (3) are fairly priced.
- **Waste** is the incurring of unnecessary costs as a result of deficient practices, systems, or controls.

It is extremely difficult to estimate the total monetary loss as a result of fraud in the health care industry. I note that our jurisdiction is over the Medicare and Medicaid programs and we have conducted numerous analyses in specific areas of these programs and have found substantial losses. For example, we know from our reviews of the Medicare secondary payer program that Medicare had inappropriately paid upwards of a billion dollars annually that should have been paid by private insurers. Similarly, after we identified problems associated with hospital credit balances, HCFA took corrective action that recovered in excess of $500 million. We can also tell you the more we look the more areas of fraud and abuse we find. Thus we can state with certainty that fraud and abuse associated with health care in this country is in the billions of dollars.

Over the years, the types of health care fraud confronted by our office has changed. In the 1970s, we found that we were largely dealing with individual providers who were involved in relatively uncomplicated schemes, such as filing false claims which resulted in a few thousand dollars of damage to the Medicare program. Today, it is more common to see cases involving groups of people who defraud the Government. Some of the schemes are relatively complex, often involving the use of sophisticated computer techniques, complicated business arrangements, and multiple locations across State lines. These crimes can cause losses in the tens of millions of dollars to Medicare and Medicaid, as well as to other public and private health insurance programs. As our health delivery system evolves we can expect to confront different types of fraud and abuse.

Because of the limited time we have today, we have selected a few examples of fraudulent and abusive practices that will give you a broad overview of the types of cases investigated by our office. The following types of fraudulent activity are among those most prevalent that we investigate (some of the case examples involve multiple abuses):

Billing For Services Not Rendered -- Most of our workload continues to involve billings for services not rendered. These cases are more readily accepted for prosecution by the United States Attorneys and are responsible for the bulk of the convictions obtained in the health care field. The following cases are examples of recent successful prosecutions involving billing for services not rendered.

- A California man illegally received almost $1 million by using various physicians' provider numbers to bill Medicare for blood circulation tests he never performed. He diverted notices of payments to 38 mail drops he controlled by putting false beneficiary addresses on the claims.

- The owner of a durable medical equipment company in Ohio solicited orders for seat lift chairs through a telemarketing firm, collected $300 to $600 from Medicare beneficiaries--many of whom were disabled--billed Medicare, but never delivered the chairs.

- An Illinois psychiatrist had to repay $300,000 to Medicare and Medicaid for submitting claims that meant he was working more than 24 hours a day.

- A unlicensed Florida physician billed services to the Medicare program which he had not provided, and in some instances, had not seen. He was able to bill the program by using his clinics' provider number and the provider numbers of licensed physicians. He used seven such provider numbers and billed Medicare approximately $1.4 million. The subject is currently under indictment.

Misrepresentation of Services Rendered -- The Medicare program loses money when providers submit claims that do not reflect the services actually performed or the supplies actually delivered. Some providers try to "game" the program by unbundling and upcoding charges. Unbundling is the billing of the subcomponent parts of an item or service rather than the complete item or service in order to inflate charges far above the appropriate level. Upcoding is the practice of billing for a more intensive service than the one actually delivered. The following cases are examples of recent successful prosecutions involving inaccurate claims:

- National Health Laboratories, Inc. (NHL), one of the nation's largest clinical laboratories, purposely designed its laboratory forms and billing procedures to induce doctors to order unnecessary laboratory tests. The company added two tests to every blood chemistry panel test ordered by a physician. Doctors were led to believe that the extra tests cost little or nothing. However, because Medicare and Medicaid claims are submitted directly to those programs by laboratory companies, the programs were billed high prices for the tests, a fact unknown to the doctors. Following the government's investigation, NHL and its president were convicted of fraud, and the total amount paid by NHL to the government in settlement was $110 million. In addition, the president of NHL served time in jail for his activities. A similar case was settled with MetPath and MetWest, for approximately $40 million.

- A Minnesota psychiatrist billed Medicare, Medicaid and the Department of Veterans Affairs for more than $60,000 for extensive psychotherapy and visits with patients in nursing and board and care homes whom he did not see or saw only in groups at meals and snacks.

- A Florida ophthalmology group paid $2.5 million to resolve claims arising from two Medicare billing schemes. In one scheme, they billed for services under an erroneous code to obtain maximum reimbursement for laser surgeries. In the other they contracted with a billing service which resubmitted to Medicare claims for individual procedures already reimbursed under global payments.

Kickbacks and Physician Self-referral -- A widespread problem in the fee-for-service area is the problem of kickbacks and physician self-referral. A kickback is the payment or receipt of anything of value as an inducement for the referral of health care business. Physician self-referral is an overlapping and similar problem. Physician self-referral is the referral for any item or service to an entity by a physician who has a "financial relationship" with that entity, and where the physician does not directly provide the item or service. The overall concern with kickbacks is that financial, rather that medical, factors may affect physician decisions about providing patients medical care.
Since 1987, we have received more than 1,967 allegations of violations of the anti-kickback statute, and have opened over 1,194 cases involving 2,099 individuals. Over 716 convictions, settlements, and exclusions have been obtained as a result of our investigations, as well as almost $25.5 million in monetary recoveries. The following are examples of recent successful prosecutions involving kickbacks:

- In 1986, a retired electrician from Chicago had a "mystery pacemaker" implanted in his chest. One could not determine the brand, serial number or even the expiration date of his pacemaker or the lead attached to his heart. The patient did not know his pacemaker was subject to failure, which would require a pacemaker replacement operation with all the attendant risks of surgery. Hundreds of other elderly patients in the Midwest also received mystery pacemakers. Why did the patient's cardiologist implant such a pacemaker? The cardiologist admitted that he received the services of a prostitute, a trip to Hawaii and other types of kickbacks from the pacemaker dealer. That dealer and nine others were convicted for mishranding pacemakers, changing their expiration dates, giving kickbacks and/or overcharging.

- A chiropractor and his wife in Georgia had to repay Medicare and more than 30 insurance companies over $2.2 million for a scheme in which employees and some 40 patients were paid a percentage of reimbursement for treatments, many of which were never done. In one instance bills were submitted for 169 persons supposedly treated in one day.

- A total of sixteen physicians, two physician assistants, three office managers and the owner of a durable medical equipment company were convicted in Florida for paying or receiving $50 to $300 each in exchange for prescriptions for oxygen concentrators or nebulizers. The company owner was ordered to repay $3.8 million to Medicaid.

- A group of Florida DME companies placed respiratory DME equipment and prescription medication with Medicare beneficiaries. This placement was done without benefit of a physician examination or authorization. After the company placed the equipment, they paid kickbacks to the physicians who agreed to sign the prescriptions for the equipment and medication, without ever seeing the patients. They then used the prescriptions as supporting documentation to obtain Medicare reimbursements of over $5.2 million. Six (6) individuals, including two physicians, have been indicted and convicted in this case.

While these types of fraudulent activities can permeate all aspects of the health care system, we have devoted significant resources to areas that appear ripe with abuse. These areas include home health agencies, psychiatric clinics, clinical laboratories, home infusion, and durable medical equipment. These areas are described in more detail below.

Home Health Agencies -- Home health agencies (HHA) provide care in the patient's home, with limited supervision by an attending physician. Several kinds of fraud occur in HHA operations: cost report fraud, excessive services or services not rendered, use of unlicensed or untrained staff; falsified plans of care and forged physicians' signatures, kickbacks, and intermediary hopping. Since 1986, we have concluded 29 successful criminal prosecutions of HHAs and their employees. Since 1991, we have excluded 27 HHAs, owners or employees from participating in Medicare.

Psychiatric Clinics -- There are approximately 700 psychiatric hospitals participating in the Medicare program. Program funds exceed $2.5 billion annually for inpatient psychiatric care. Our

investigations lead us to believe that the major concern is the medical necessity of lengthy hospital stays. We are also concerned about kickbacks and other incentive arrangements between the hospitals and practitioners ordering psychiatric hospitalization. In a scheme we saw recently, hospitals paid physicians up to $2,000 for each patient referral. The clinics included payment to doctors in their cost reports they submit to Medicare. The payments doctors received were ostensibly for writing manuals for the clinics to use in the care of patients, but these manuals were never written. The OIG has several ongoing investigations (with the FBI) of psychiatric hospitals.

Clinical Laboratories -- Our investigations into clinical laboratories indicated that the major fraud in this area is over-utilization. The laboratories bill the Medicare program directly and beneficiaries are not liable for any cost sharing. As a result, neither physicians nor beneficiaries have adequate information or incentive to monitor utilization or costs. The marketing of tests by laboratories also encourages their over-utilization while maximizing reimbursement from Medicare and Medicaid. Many tests are performed on automated equipment capable of conducting multiple analyses on a single specimen. While the profiles are marketed to non-Medicare users as a single product, we are concerned that some laboratories unbundle the tests by billing Medicare for individual tests. Program expenditures for clinical laboratories was over $1.7 billion dollars in 1993. In the last 3 years, eight convictions have been obtained as a result of our laboratory investigations.

Home Infusion -- Home infusion is one of the fastest growing segments of home health care in the U.S. (about $4 billion annually), and is still in its infancy as compared to other home care services. We believe that kickbacks in the form of case management fees or fees for service are used as incentives for physicians to refer patients to a particular company. Payment averages $150 per week per patient. Doctors have made $10,000 per month in kickbacks. Kickbacks are disguised as service agreements, research grants, partnerships, stock options, and dummy corporations. We have received a number of additional allegations in this area including unbundling, ghost patients, nutritional needs that fall short of those needed to sustain life, and "diverted" drugs and nutrition used in infusion therapy.

Durable Medical Equipment (DME) -- For many years, we have issued reports documenting fraudulent, abusive and wasteful practices in the DME area. Seat lift mechanisms, transcutaneous electrical nerve stimulators (TENS), oxygen equipment, home dialysis systems and similar equipment are reimbursed by Medicare and Medicaid only if prescribed by physicians as medically necessary. Unscrupulous suppliers throughout the country circumvent this requirement through aggressive sales practices, tricking physicians into signing authorizations and even forging their signature. Some suppliers simply bill for items never delivered; others bill carriers in States which pay high Medicare reimbursement, regardless of where the sale took place. In the last 3 years alone, over 73 convictions have been obtained in this area. We are pleased that the Department is currently undertaking reforms which will change point-of-sale rules and how provider numbers are issued.

ADDITIONAL REFORMS NEEDED

We believe that three major problems must be addressed if we are to reduce fraud and abuse in our health care system. First, the basic structure of the current health care system needs to be simplified. The health care system is vulnerable because of its size, complexity, and the fragmentation of processes and information systems used to administer benefits. Today, over 1,000 payers process 4 billion claims a year, covering 1.6 million different providers. This is exacerbated by the fact that different payers use different claim forms, payment methods and coding procedures. Given the need for prompt claims payment, payers have little time and less incentive to trace patterns of fraud through the maze of contractors, providers, suppliers, billing services and data systems that comprise the current system.

Second, the lack of resources to identify waste and combat fraud and abuse is a major problem because it allows harmful practices to continue and defrauders and abusers to escape detection. The limited resources available are inadequate to address sophisticated and complex schemes to defraud and abuse health care programs. To enhance resources for combatting fraud and abuse, we support the establishment of an All-Payer Health Care Fraud and Abuse Control Account. Funds for this account should include Federal criminal, civil, and administrative penalties other than funds returned to original payers, such as the Medicare trust funds or the States.

Third, several statutory improvements could be made to protect citizens and their health care plans from unscrupulous providers. While we believe that we have been successful in combatting fraud and abuse in the Medicare and Medicaid programs, certain statutory modifications could be made to decrease program abuses. In addition, while the Federal Government currently has many authorities to combat fraud and abuse in the Medicare and Medicaid programs, similar authorities to address abuses in private health plans do not exist. Possible modifications to address these deficiencies include:

- Civil monetary penalties should be added for activities such as kickbacks, routine waiver of copayments (with appropriate exceptions, e.g., for low income individuals), and upcoding.

- The current Medicare ban on payments for physician self-referrals should be broadened to include any item or service not rendered by the physician personally or by a person under the physician's direct supervision. Many of the existing exceptions should be revised, such as the in-office ancillary services, prepaid plans, and physician recruitment exception.

- A mandatory exclusion should be added for individuals or entities convicted, in connection with delivery of health care items or services, of fraud or financial misconduct. In addition, minimum periods or exclusions should be established for certain bases of exclusions.

- Current civil monetary penalty authorities should be expanded to authorize the Federal Government to assess penalties against persons who engage in specified activities with respect to any health plan. The basis for these penalties should include, for example, false claims and false statements in claims, or false advertising to the public.

- Civil monetary penalties should also be aimed at managed care abuses, which are very different than those that exist in fee-for-service medicine (where there is an incentive to order more services). Abuses that may occur include "skimming," which is discouraging the enrollment of (or actually disenrolling) unhealthy patients or patients in high risk groups, or denying patients expensive care even when it is medically indicated.

- Current Federal exclusion authorities should be expanded to authorize HHS to exclude a provider from participation in all public and private health care programs.

- Current Medicare-Medicaid prohibitions on kickbacks and physician self-referral should be extended to all public and private payers. (Health care items and services that are paid on an at-risk, capitated basis do not have similar over utilization concerns. Therefore, any reform should include appropriate exceptions for certain managed care plans and capitated payments to providers.)

- A database of all final adverse actions against health care practitioners should be established with appropriate safeguards for privacy and access.

In addition to addressing these problems, it is critical that the effort to combat health care fraud be well coordinated. There are numerous Federal, State and local law enforcement groups with a stake in investigating and prosecuting health care fraud. These include the Department of Justice and the Federal Bureau of Investigations; the Inspectors General at HHS, the Department of Defense, the Department of Labor, and the Department of Veterans Affairs, the United States Postal Service, State Medicaid Fraud Control Units and State Attorneys General; and HCFA and Medicare contractor fraud units. Only by working together can we effectively use the resources of these various entities to combat fraud and abuse.

CONCLUSION

The types of fraud that I have discussed in my testimony today could be avoided or lessened by closing loopholes that exist in the law or in Medicare rules and regulations. Hearings such as this help draw attention to these important problems that confront and weaken our health care delivery system. In addition, as the Congress and the Nation contemplate changes to our health care system, we believe that the problems of fraud, waste, and abuse must be addressed.

This concludes my prepared testimony. I shall be happy to answer any questions you may have.

Senator GRAHAM. Thank you very much, Mr. Hallmark.

Mr. George Clow, special agent in charge for the Miami division of the Federal Bureau of Investigation.

STATEMENT OF GEORGE B. CLOW III, SPECIAL AGENT IN CHARGE, MIAMI DIVISION, FEDERAL BUREAU OF INVESTIGATION, MIAMI, FL

Mr. CLOW. Senator Graham and Senator Pressler, I appreciate this opportunity to comment on the FBI's efforts in combating health care fraud in south Florida.

In 1992 Medicare benefit payments totaled approximately $130 billion, of which 10 percent, or approximately $13 billion, was spent in the State of Florida. The General Accounting Office has estimated that up to 10 percent of all national health expenditures are lost to fraud. If Medicare is suffering from the same total rate of fraud, up to $1.3 billion of Medicare benefit spending in Florida would be wasted on payments for fraudulent health care practices.

The FBI commends your support in pursuing those who defraud the health care system. Prior to commenting on the health care fraud problem in south Florida, I would like to stress that it is not my intention or the FBI's to malign all health care providers in the State. In fact, the vast majority of these are honest, hardworking, law-abiding professional and business people who demonstrate integrity in the conduct of their businesses.

Since the establishment of the Miami health care fraud unit in April 1992 this office has successfully investigated reported instances of health care fraud, which have led to 55 indictments or 16 percent of the total of 332 indictments recorded by the FBI nationwide. Most FBI health care fraud cases in south Florida are predicated on information received from citizens or from informants and cooperating witnesses and referrals from other Federal and State agencies. To appropriately address the health care crime problem the FBI works jointly and in cooperation with the inspector general's office for the Department of Health and Human Services, the State of Florida Medicaid fraud control unit, and the U.S. Food and Drug Administration. We also work with the Florida insurance department and other State agencies. We also confer with and receive information from other State and Federal regulatory agencies, professional health organizations, and private insurance organizations and companies. In south Florida the inspector general's office for the Department of Health and Human Services has four investigators, and the State Medicaid control unit has 14 investigators. The FBI's health care squad consists of one supervisor and 10 agents. The indictments obtained as a result of this cooperative effort demonstrate the FBI's success and the success of all the agencies in addressing the national health care initiative in south Florida.

In the course of our investigations, the Miami office of the FBI has identified various types of fraud schemes in many segments of the health care industry. Of these schemes the most prevalent in south Florida are frauds by medical clinics, durable medical equipment suppliers, doctors, and home health agencies.

Some medical clinics defraud the health care system by luring Medicare and Medicaid beneficiaries and people insured by private

companies with cash payments. We have heard from witness testimony today how that is done. The clinics then perform unnecessary diagnostic tests on the patient in order to generate revenue from the Government or private insurance companies. These medical clinics may also add on charges for tests which are not performed and fictitious visits by the patients to the clinics.

Durable medical equipment fraud is also a significant criminal problem in south Florida. These problems are perpetrated through several schemes. For example, medical equipment companies go door to door, handing out free equipment, pay doctors to prescribe this equipment for the recipients, and then bill Medicare and private insurance companies for it. Liquid nutritional supplements, often referred to as medical milk—and Ms. Gual testified to that quite convincingly—are one of the products currently being used very extensively in south Florida to defraud Medicare.

Some physicians commit fraud by the submission of false claims. False billings by doctors generally occur when:

One, the service was never rendered; two, a service was rendered, but a more expensive procedure was billed; three, the service was performed fewer times than it was billed; and four, the diagnostic code on the billing is altered to purportedly justify more expensive treatment and procedures.

Some health care providers commit fraud by billing the Government for home health care not provided, paying kickbacks to hospital staff and doctors for patient referrals, and billing the Government for more visits and services than were actually rendered.

Senator Graham and Senator Pressler, I have touched on just a few of the segments of the health care industry the FBI is actively investigating in south Florida. There are many other areas of health care where allegations have surfaced which require further inquiry and review for possible criminal prosecution and maybe civil action, also.

The FBI is dedicated to preserving the integrity of the health care system by aggressively pursuing health care fraud investigations in south Florida and throughout the United States.

The FBI is also certainly appreciative of the support by Congress on this important issue as evidenced by these hearings today.

I would also like to add that I completely concur with what Ms. Rager and Ms. Gual and Dr. Rodriguez have said. An ounce of prevention is worth a pound of cure. In this particular type of crime, where we are becoming involved in paper investigations that are extremely manpower intensive, extremely resource intensive, it would seem that by better ensuring that this type of fraud is cut off before it could occur, that that would be the most cost effective and appropriate answer for this particular problem.

Senator GRAHAM. Thank you very much, Mr. Clow.

Mr. John Morris, who is with the Medicaid fraud unit of the State of Florida.

STATEMENT OF JOHN MORRIS, DIRECTOR, FLORIDA MEDICAID FRAUD UNIT, TALLAHASSEE, FL

Mr. MORRIS. Senator Graham and Senator Pressler, I want to thank you on behalf of the State of Florida for holding this hearing

here on behalf of the many agencies that are involved in the investigation of Medicare fraud.

I would like to very briefly discuss some of the similarities and differences between Medicare and Medicaid Programs.

First, as you are aware, the Medicare Program is designed primarily for the elderly and is administered by the Health Care Finance Administration within the Department of Health and Human Services; whereas the Medicaid Program is designed to meet the needs of the medically needy and is administered by the individual States. I would like to point out that many individuals qualify for and receive benefits under both programs.

The benefits received under the Medicare Program are basically the same throughout the country. However, the benefits under the Medicaid Program can be quite different since each State sets up and runs its own program, although every State does provide the benefits that are required under the basic 10 programs.

The Medicare Program is paid for with total Federal funding while the Medicaid Program is a State-Federal partnership with the Federal share being determined using a formula that involves the average per capita income of the State residents.

As has been indicated, of the Medicare/Medicaid payments for the State of Florida last year, assume we use the GAO accounting estimate of 10 percent across, fraud equals roughly $1½ to $2 billion.

The schemes used by the various unscrupulous providers vary little between the Medicare and Medicaid Programs. Generally speaking, if a provider is submitting false claims to the Medicaid Program, there is a very high likelihood that he is also submitting claims to the Medicare Program and possibly to private insurers. If a recipient happens to be eligible for benefits under both programs, there is a good probability that the provider may be stealing from both programs since he only submits one claim to the Medicare Program. When he submits that claim, he receives 80 percent of the Medicare. The Medicare fiscal agent forwards it to the State Medicaid Program, and the State at that point pays the remaining 20 percent.

The various schemes used by the Medicare provider are generally also used by the providers in defrauding the Medicaid Program. One of the major problems we are seeing today is in the home health area, where we have providers billing for services not rendered, providers billing for services allegedly rendered to deceased patients, and providers who are billing for services allegedly provided by a registered nurse, when in fact the service was provided by a licensed practical nurse. Fortunately, we have not observed a situation where the person's health or welfare was placed in jeopardy because of service rendered by an unqualified individual.

We are aware of schemes where medical clinics are recruiting patients, offering them money or, in some cases, items such as groceries. We are also aware that providers sell lists of recipient names and numbers to each other so they can get Medicare or Medicaid. The list of these schemes goes on and on.

One comment I would like to add in regard to the question that Senator Pressler raised is: Currently in nursing homes we have a

situation where the Medicaid Program is unknowingly paying payments for items that the Medicare Program has also paid for.

It should be noted that a change in the delivery system will not change the fact that there are going to be certain segments of providers who will continue to steal from the system. While the current trend is a move toward a managed care concept, it should be noted that this delivery system already has unscrupulous providers who have found new and innovative ways to profit criminally. State Medicaid fraud control units have already documented several types of criminal activity in these managed care programs, including kickbacks, rebates, and other illegal economic arrangements, tax evasion, fraudulent subcontracts, and excessive salaries and fees.

At this time I would like to direct my remarks to the conducting of these investigations. As has been pointed out, whether you are conducting Medicare or Medicaid investigations the problems are very much the same. The cases are complex and you deal with a great deal of paper work trying to get people to recall an event that may have occurred several months ago. The investigator conducting the investigation must have an expertise of the program and be able to investigate, plus having a working knowledge of medical terminology.

As the health care business continues to grow toward the day when we have over $1 trillion in expenditures, it becomes obvious that we need several things. First, we need more resources at both the State and Federal level, both in the area of investigations and in prosecutions. Second, we need some clearinghouses or some other mechanism that would allow for sharing of investigative information and provide for common databases that would aid in the investigation. Third, we need to review some restrictions on the ability to share information between State and Federal agencies and possibly with private insurers who conduct these investigations.

That concludes my remarks at this point. I will be happy to respond to any questions.

[The prepared statement of Mr. Morris follows:]

TESTIMONY OF

JOHN G. MORRIS, JR.

DIRECTOR, FLORIDA

MEDICAID FRAUD CONTROL UNIT

Mr. Chairman, Members of the Committee:

As Director of the Florida Medicaid Fraud Control Unit, I am very pleased to appear before you today to discuss fraud and abuse in the Medicare and Medicaid programs in the State of Florida.

I would like to very briefly discuss some of the similarities and differences in the two programs. First as you are aware the Medicare program is designed primarily for the elderly and is administered by the Health Care Finance Administration within the Department of Health and Human Services. Whereas the Medicaid program is designed to meet the needs of the medically needy and is administered by the individual states. I would like to point out that many individuals qualify for and receive benefits under both programs.

The benefits received under the Medicare program are basically the same throughout the country. However, the benefits under the Medicaid program can be quite different since each state sets up and runs its own program, although every state does provide the benefits that are required under the required 10 programs.

The Medicare program is paid for with total federal funding while the Medicaid program is a state-federal partnership with the federal share being determined using a formula that involves the average per capita income of the state residents.

In Florida last year Medicare benefits totalled approximately 8.0 billion dollars and Medicaid payments were between 5.5 and 6.0 billion dollars for a total of almost 14 billion dollars. While there may not be a way to establish an exact amount of fraud and abuse in health care, the General

Accounting Office (GAO) recently estimated the figure to be 10%. Using that 10% figure it is easy to calculate that the fraudulent payments in the Medicare and Medicaid program last year could be as high as 1.4 billion dollars.

The schemes used by the unscrupulous provider(s) vary little between the Medicare and Medicaid programs. Generally speaking if a provider is submitting false claims to the Medicaid program there is a very high likelihood that he is also submitting claims to the Medicare program, and also to private insurers in many cases. If a recipient happens to be eligible for benefits under both programs then there is a good probability that the provider may be stealing from both programs and he has submitted only one claim. This can be accomplished because the provider submits the original claim to Medicare who pays 80% and Medicare than passes that claim on to Medicaid who pays the remaining 20%.

The various schemes used by the Medicare provider are generally also used by that same provider in defrauding the Medicaid program. One of the major problems we are seeing today is in the home health area where we have providers billing for services not rendered, providers billing for services allegedly rendered to deceased patients and providers who are billing for services allegedly provided by a Registered Nurse, when in fact the service was provided by a licensed practical nurse. Fortunately, we have not observed a situation where a persons health or welfare was placed in jeopardy because of service rendered by an unqualified individual.

We are aware of schemes where medical clinics are recruiting patients, offering them money or in some cases items such as groceries. We are also aware that providers sell lists of recipient names and numbers to each other so that they can get new Medicare or Medicaid numbers for billing. The list of the various types of schemes being used is lengthy and grows daily.

It should be noted that changing the delivery system will not change the fact that there is a certain segment of providers that will continue to steal from the system. While the current trend is a move toward a managed care concept it should be noted this delivery system already has unscrupulous providers who have found new and innovative ways to profit criminally. State Medicaid Fraud Control Units have already documented several types of criminal activity in managed care plans including, kickbacks, rebates and other illegal economic arrangements, tax evasion, fraudulent subcontracts, and excessive salaries and fees to participating entrepreneurs.

At this time I would like to direct my remarks to the conducting of the investigations. Whether you are conducting a Medicare or Medicaid investigation the problems are very much the same. These cases are complex in that you are dealing with a great deal of paperwork and you are trying to get people to recall an event that may have occurred several months ago. The investigator conducting the investigation must have an expertise of the program that is being investigated plus an added knowledge of medical terminology is helpful.

As the health care business continues to grow toward the day when we have over one trillion dollars in expenditures, it becomes obvious that we need several things. First, we need more resources at both the state and federal level. Both in the area of investigation and prosecution. Secondly, we need clearinghouses or some other mechanism that would allow for the sharing of investigative information and provide for common databases that would aid in the investigation. Third, we need to review the restrictions on the ability to share information between state and federal agencies and possibly with private insurer investigative units.

Lastly, I would point out that the state Medicaid Fraud Control Units have been in existence for over 15 years. During that time they have proven to be successful and have developed a great deal of expertise in health care fraud investigations and prosecutions. These units could easily be modified to become Health Care Fraud Control Units with the authority to investigate Medicare and Medicaid Fraud and possibly fraud in the private insurance arena.

Senator GRAHAM. Thank you very much, Mr. Morris.

Mr. Hallmark, I believe you indicated there were some 70 providers who were delisted from the program because of inappropriate activities. Is that correct?

Mr. HALLMARK. That were excluded last year from the health care program here in Florida.

Senator GRAHAM. Do you know what happened to those 70 people relative to any licensure that they might have had, such as a State medical licensure or State license to operate a hospital or a home health care unit?

Mr. HALLMARK. I do not know specifically how many of them had their licenses revoked by the State agency. They would be prohibited from utilizing those individuals in a health care setting that is reimbursed by Medicare or Medicaid or any of the other State health care programs.

Senator GRAHAM. Is there a reference made to the State licensure agency when you delist an individual or an institution?

Mr. HALLMARK. Yes, there is.

Senator GRAHAM. Mr. Hallmark, in May 1992 the General Accounting Office released a report on Medicare fraud. The principal recommendation was the establishment of mechanisms for a greater collaborative effort to address fraud and abuse, including public health insurance programs, private health providers, State and Federal law enforcement agencies. What has occurred since that report was issued in May 1992?

Mr. HALLMARK. I think we have health care fraud task forces in virtually every judicial district in the country. We work very closely on these health care fraud task forces not only with the Department of Justice and the U.S. attorneys' offices, but with the FBI and the Postal Inspection Service working on private insurance fraud, because, as has been pointed out, many times these individuals are not just ripping off the Medicare Program, they are also ripping off Medicaid and private insurance companies as well.

Senator GRAHAM. So in your judgment, were the recommendations that were made in 1992 effectively implemented?

Mr. HALLMARK. I think they were, because, as I said, I believe we have health care task forces in virtually every U.S. attorneys' office in every district in the United States.

Senator GRAHAM. Mr. Coffey, could you elaborate on how that task force is staffed and functioning here in south Florida?

Mr. COFFEY. The task force, Senator, is essentially a meeting ground for representatives of the different agencies, and it is not per se a beneficiary separate staff, that is to say as opposed to some of the programs where in setting up the task force it is created by congressional law, so we may have dedicated resources that are available solely to work as a task force. You have full-time staffing for a task force. We have office and category of resources that are available to that task force. We do not have any of those resources together. Instead, what we do is we meet in a working group in some ways; another way to describe the thing, simply to share information, cooperate, discuss matters of common concern and make sure that we have as much coordination as we can.

As programs of law enforcement get more and more resources, it is not an unusual scenario to have a classical task force in the

sense of dedicated funding, personnel, even colocation of different agents and attorneys. There are a number of task forces. It seems to me that it is certainly something that is worth further resources and study by the committee.

Senator GRAHAM. What recommendations might you have as to how this system might work more effectively?

Mr. COFFEY. Well, the focus is on task forces. We, and I suppose like everybody that is in Government in our position, would obviously advocate more resources. Here, I think, you can prove in dollars and cents. The HHS ratio is a spectacular one. The Bureau is also extremely effective. We could show what we could do to save the taxpayers hundreds of millions of dollars, just here in south Florida, if sufficient resources were made available.

So what you look to see done is a structure which dedicates positions in the U.S. Attorneys' Office, the Bureau, HHS to work as part of the task force structure. Sometimes you have money that is made available to fund particular investigations. Investigations are like a lot of other things. Yes, people who are already working can do them. Whether the effort is overtime or needs for surveillance expenses, undercover expenses, things like that, having separate money made available to fund specific approved investigations by a task force is highly beneficial.

We would suggest that models could be found for this sort of task force without requiring a great deal of reinventing of wheels. There are models that are extremely valid that pull together State and Federal and are applicable, prove particular investigations and make sure that there is a tremendous amount of communication. Were it to be considered useful to actually colocate agency representatives so they are working together on the same floor, we do do that. An example is high intensity drug trafficking area programs here in south Florida and elsewhere. We literally have different agents working side by side. Obviously that maximizes the information sharing. That would be another feature to consider as well, Senator.

Senator GRAHAM. I would like to get some statistics on the resources which are available in south Florida in relationship to the number of cases that you are pursuing. The material that I had indicated that the south Florida Office of Inspector General had four agents and two support personnel to find the public Medicare fraud. Is that accurate?

Mr. HALLMARK. I think that we have got four agents here in south Florida. Actually we have four agents up in Tampa that are occasionally assigned to work here in south Florida on large-scale cases that we have to do so they will have to expend travel money to be able to carry out those functions. We have two agents in Orlando, along with two support staff in Orlando. The support staff covers the entire State, not just south Florida.

Senator GRAHAM. How many cases does the south Florida office have at present for investigation and need legal counsel?

Mr. HALLMARK. The case load of the agents will vary. It probably runs 20 to 25 cases per agent.

Senator GRAHAM. Twenty to twenty-five cases?

Mr. HALLMARK. Per agent.

Senator GRAHAM. Thank you. We have statistics that indicate that there were some 10,000 complaints last year. Is that figure accurate, and if so, how do you convert a complaint into a case?

Mr. HALLMARK. I am not aware of the 10,000 complaints. I do not know what that figure represents.

I do know that we received a large number of complaints. I do know that last year nationwide we had over 2,000 complaints that came in, that we either referred directly to the FBI or another law enforcement agency, because we did not have the staff to look at it, or referred it back to the carrier or intermediary, the source of the complaint, to take administrative action just to recoup the dollars, because we did not have the staff.

As for that 10,000, I do not know that number.

Senator GRAHAM. It also stated that there were some 3,000 cases pending in the Tallahassee office at the time that office was closed. What happened to those cases?

Mr. HALLMARK. I am not aware of 3,000 cases pending in the Tallahassee office. I can state that that is an inaccurate figure.

Senator GRAHAM. The FBI, what are your number of personnel devoted to Medicare fraud in south Florida, and what is your case load?

Mr. CLOW. Right now, Senator, we have 10 agents and a supervisor, full-time comprising a squad that is located in an office in Fort Lauderdale.

Currently we have 26 pending investigations.

As I said earlier in my prepared remarks, these cases are extremely manpower and labor intensive. Numbers do not necessarily reflect the work load. All of these cases involve an extreme amount of records that need to be reviewed. Our case load is, again, what we consider to be the most promising and most significant in terms of dollar losses. We have an unaddressed work file that contains cases that are waiting in line to be investigated when the investigators are freed up. The unaddressed work that is pending in the Miami office, which encompasses most of south Florida, could occupy the full-time efforts of an additional six agents, and we have made that request from our headquarters to be so staffed.

Senator GRAHAM. You requisitioned 6 additional agents to the 10 that are currently involved in Medicare fraud?

Mr. CLOW. Yes. We would need at least six to handle the unaddressed work. The request actually was for 10 agents which would give us the freedom to employ some techniques we are not now able to employ.

We are now basically just reacting to crimes that have already occurred. We would like to do more in terms of pro-active work to address firms that are brought to our attention which are engaged in the type of practices that we have heard about today and be able to actually target those through the use of undercover techniques, the use of consensual recordings being made by cooperative witnesses and the use of electronic, court-authorized electronic surveillance.

Senator GRAHAM. Could you give me again, Mr. Clow, the number of cases per agent?

Mr. CLOW. It comes to about 2.6; 26 pending cases for 10 investigators, Senator.

Senator GRAHAM. Mr. Coffey, what is your resources versus cases?

Mr. COFFEY. Everyone would like more AUSA's. But our focus, Senator, has been to advocate for more investigative agents. I would love, if I could have a wish list, even before increasing the staffing in my own office which I would love to see of course, it would be a further commitment of agents to the Bureau's staffing and, of course, to HHS.

We have probably as many AUSA's with experience and skill in health care fraud as exists anywhere in the country. There are close to 20 AUSA's who have a basic familiarity and capability of acting in health care fraud. A number are full-time. Some are handling two or three cases each. But our number of indicted defendants, which is well into the mid fifties, is considered by national standards the highest. Of course, as I have mentioned, we have an increasing number of civil cases because, it was referred to by Dr. Rodriguez and I think it is acknowledged in some parts by you and Senator Pressler, we cannot begin to reach the dimensions of this problem simply through criminal prosecutions. In terms of civil cases we have got more than a dozen that are active now and there are many, many more that are pending the investigative stage. In terms of the criminal cases, in addition to that number of indictments, there are a large number of pending investigations.

But I would say that for both HHS and the FBI, the more significant number may be in the work place unaddressed, because they do not have the agents to do more than they are already doing. They are doing a superb job.

Senator GRAHAM. Senator Pressler.

Senator PRESSLER. Yes. Thank you.

I want to follow up on a few of those questions by asking: First of all, I guess medicine is the kind of thing that is hard to measure. I was talking to a doctor with a practice where he has a lot of poor patients and some rich patients and some who have insurance and some who do not. He said that he has to average all of this out. He is sort of a modern Robin Hood, so to speak, because medicine is the kind of thing that you can make more charges for some patients or less charges for another.

I have talked to a small town hospital administrator, and this could be a small hospital in a big city, too. They said: I get a third of my revenues from Medicare, a fourth of my revenue from VA referrals, and I have some people in the community who are not covered and we have got to take care of them, and the kind of pay patients that can carry a heavier load. So there is a certain amount of shuffling around that is done legally, I suppose. It is not like you are selling widgets from a factory and every one is worth $5.

So I suppose there is always a chance that people are accused of fraud or assumed of fraud when they are making judgments, but then we have the outright blatant fraud, I suppose.

From the figures we have thrown around here today, and somebody tells me in south Florida for example—I do not think south Florida is any different from probably any other part of the country, if you average things out and average conditions out—what percentage of fraud are we talking about?

My figures show $1 in $4 are going to fraud and abuse. What do your numbers show? What percentage in south Florida go to fraud and abuse?

Mr. COFFEY. Well, Senator, I will jump in on that.

We think the problem in south Florida is quite a bit worse than the rest of the country. I think you had indications of that from the fact that 16 percent, as Special Agent Clow testified, 16 percent of the FBI indictments are down here in south Florida. That is compared to offices in New York and Los Angeles and Chicago, and all around the rest of the country.

We also know that the problem here is quite a bit worse because the Medicare expenditures in Dade County are just that much higher per capita than anywhere in the rest of the country.

The problem is serious everywhere. We know that there is sort of a bench mark of 10 percent that is used as a national average.

I would submit that the problem is at least twice that bad down here in south Florida and could be a lot worse. Where it becomes difficult to be a precise answer is as you get to the grey zone of what is fraud, precisely the point of view. We are trying to focus not on plus costs of a physician's judgment. We are not even in that ball park. What we are looking at are the kind of cases that were testified about today, where rank, unabashed criminality is taking place, and where clear-cut laundering is taking place, but that is more properly remedied through civil procedures.

If I were to give you my own assessment, it would be to multiply at least by twofold the 10 percent bench mark that is used nationally.

Senator PRESSLER. You estimate to be how much the total abuse numbers? One dollar in five is the——

Mr. COFFEY. That is my estimate, Senator. Yes.

Senator PRESSLER. Is there anything you have need to add to that or subtract?

Mr. CLOW. Senator, one thing I might add is that one of the problems I think we have is trying to gauge this very thing. How do we measure what the extent of the fraud is?

The Chamber of Commerce estimates between 5 and 20 percent of all insurance claims are fraudulent. GAO claims 10 percent of the Medicare claims nationwide are possibly fraudulent. The FBI, when addressing the bank failure problem in the late 1980's, instituted a referral system whereby we could track the amount of reported fraud and perhaps it is time we do something like that again. Whether it would be the FBI or some other agency maintaining that sort of system, I think we need to get a handle on how big a problem this is. I really do not think we have a very good, exact sense, as our U.S. attorney pointed out, of the actual extent of the problem.

Senator PRESSLER. Has the administration asked for more FBI agents or for more inspectors? Did the President's budget ask for more and Congress denied him those additional people?

Mr. CLOW. Senator, it is my understanding that additional agents to work this type of fraud were not requested over and above those already existing in the FBI. My understanding of what the budget request was based upon reflected that there was a growing realization that the savings and loan crisis was ending,

and it was our sense, the FBI's sense, that a number of agents who had been brought on duty to investigate the crimes in that program could possibly be freed up and redistributed to address health care fraud.

What the FBI is attempting to do is reprogram agents for that priority and redistribute them to where this problem is.

Senator PRESSLER. Are you going to be able to do that? You are going to get enough people?

We are getting $61 back for every dollar we put in. It looks like this would be a good place for us to put some more money—not that we have it, we have a huge deficit, you know. But I am trying to get to the point—I am sure that George Bush's administration and Bill Clinton's administration covers about the same here—maybe they should be requesting more agents, once you get the people shifted off of savings and loans. You never have enough. You can always have more of everything.

But we have got to handle the problem as it has been. Do we have a grip on it?

Mr. CLOW. It is the articulated position of our headquarters that we will.

One of the problems they are encountering now is that agents who were hired to address bank failure problems are in different parts of the country than where this problem is cropping up, so we are having a problem of getting the resources to where they need to be applied to address the current problem. The FBI is just coming to grips with that right now.

Senator PRESSLER. I wonder if the staff could find out what the OMB and at least tell me, and then maybe we could put it in as a question, what the OMB sent over, because if we in Congress are not doing our job, then it is our fault in part because we can always add more money.

I would be very curious as to what has been requested by the administrations, so if we could do that.

Let me ask a little bit different slant here.

Now in my State we have the Indian Health Care Services, and there is great fraud abuse there, or waste—maybe it is waste as much as anything. We have a number of other government programs. Now we are about to embark upon the Clinton health care plan. Maybe it will be the Chafee plan, or maybe it will be the Dole/Moynihan substitute, but it appears that the Federal Government is about to get more involved in providing health services to the American people, and it will be about the same kind of a deal where you have insurance companies involved and so forth.

Could we anticipate that we are going to be losing 16 percent or $1 in $5 on fraud and abuse in any new health programs that we have? Is this endemic to the situation?

We have Medicare and we have the Indian Health Care Services, and that is about what we are losing. We are losing about 20 percent on fraud. Do we have to just assume that that is a built-in cost? Are there things we can do about it?

Mr. HALLMARK. I think that you could say that any time you have that much money that is going to be out there in any program that those individuals who are so inclined to defraud programs will do so. I do not think it makes a lot of difference what you call the

program, whether you call it three different programs, including Indian Health Services, or whether you call it one national health program. If the providers are inclined to do so, they will find a way to defraud programs.

Yes, you will have fraud. It will continue to exist.

Mr. COFFEY. Senator, sort of to analogize to a field of dreams, if you put the Federal money there the criminals will come. But whether it has to be as bad as is the current experience in south Florida is a fundamentally different question.

I think my perspective is a great deal different. Again, we are talking about so much money, moving that percentage of fraud down just even a few points means saving an awful lot of dollars. We certainly endorse the reallocation of Federal Bureau of Investigation agencies, as Special Agent Clow described, to health care.

Obviously it is no secret that my office has been of the view that a significant increase in HHS resources is necessary. I think that will make a difference. Once the risk factor gets up there for perpetrators of health care fraud, there is a category of fence straddlers that will get out of business.

The worst, the most insidious, the most skillful and hard-core, we are not going to chase them out. We are going to have to drag them in chains and put them in prison.

But there will be a category of fence straddlers that we can drive out of business. I think as all of us are more aware of the challenges of health care fraud, you and Senator Graham and your colleagues will find things that can be done to punish.

Whether there will need to be more consideration given to reviewing of background, background people for providers. What kind of brief verification can we do? What kind of spot checks, random checks can computer software perform? More and more, I think, happens at the front end of the process.

The various agencies in private industry components are getting smarter and more experienced and more effective. I think that, combined with the kind of enhanced law enforcement and, frankly, just a lot of good citizenship as has occurred at this hearing this morning will cause us to make enough of a difference to be significant, a difference that will ultimately mean billions of dollars that is not stolen and hopefully billions of health care that is provided to those that need it.

Senator PRESSLER. Although I guess some of that good citizenship that we have seen here this morning would probably go away frustrated, in frustration.

Let me ask one more question, and that is: If you had to rank on a scale of 1 to 10 who is most guilty in fraud cases—we have not talked about the insurance companies who administer these programs—I guess you would have to have a doctor involved, you would have to have an administrator involved, you would have to have an insurance company passing over this thing. A lot of doctors though say they are so busy practicing medicine in their clinics or their hospital that they leave the billing. A lot of doctors never think about billing.

Would there have to be an administrator and a doctor and a company involved in each of these cases where there is real fraud?

So on a scale of 1 to 10, how would you place the administrators, how would you place the doctors, and how would you place the insurance companies?

Does anybody want to tackle that?

Who are the real culprits here? Who is doing this?

Mr. COFFEY. I will jump into this observation.

There is a pattern of a crooked entrepreneur here, not necessarily a doctor. They are finding in some instances, the pattern is varied, doctors will sign these things in blank, these certificates for Medicare, so whatever the case they are finding doctors. But ultimately it is a crooked entrepreneur who hears that there is a lot of dough to be paid in health care fraud and is learning the system and learning how to beat the system as it stands now. It is the kind of person that I think is springing up everywhere.

Senator PRESSLER. But there are factors. You know, we have these sophisticated computers now. There are programs that are written that would flag probable fraud to whoever is administering the program, but has probably already been done.

Mr. COFFEY. That is part of what is being done and is being developed and where I see hope for significant improvement.

Senator PRESSLER. I thank you very much.

I may ask additional questions for the record later.

Senator GRAHAM. Senator Pressler, those are certainly excellent questions. I am sorry that we did not have available for the hearing today representatives of the administrators of the programs, such as Blue Cross/Blue Shield and Aetna, who could have given us some additional information as to what systems they do use or might commonly use to meet those objectives.

If we have a subsequent hearing of this committee on the subject of Medicare fraud, and I am going to recommend that we do so, maybe we will be able to pursue that issue further at that time.

Mr. Morris, you talked about some of the coordination between Federal and State fraud programs. You are primarily involved in a program which is, by its nature, a highly Federal/State initiative. What recommendations might you make in your experience as to how the State, including specific fraud units such as yourself, also licensure boards, also private professional associations such as medical associations might participate with your Federal counterparts in a more effective coordinated effort?

Mr. MORRIS. Senator, as I indicated, we have been very involved in the health care task forces. We sit on the task force both here in south Florida and in another two U.S. attorneys' offices.

As I indicated during my remarks, I think one of the critical things that we need to do today is to coordinate our efforts, whether it is the FBI, whether it is HHS. We are all working toward the same goal and that is to get that unscrupulous provider out of there.

We can all use additional resources. We have a request in our State legislature asking for additional resources at this time.

Fraud is a big problem. We have to work together.

As I indicated also, I would like the ability to see some sharing of information, right down to certain restrictions on getting information in the past, back and forth between State and Federal agencies. I think those rules and regulations need to be looked at

to see if they can be loosened. If they cannot, that is a problem I have to work around, but I think it certainly should be looked at.

Those are a couple of the things that I think would be very important.

Senator GRAHAM. What kinds of information have you had difficulty getting access to?

Mr. MORRIS. Certain grand jury information unless we are part of the grand jury GE order. And when we have worked with the U.S. Attorneys' office, for example, we will have a limited number of investigators and maybe one or two that may be involved with other agencies and the only individual who has access to that particular information, so it restricts us to a certain extent in that area.

Senator GRAHAM. Senator.

Senator PRESSLER. I would just like to follow up the question.

We had a case by one of the witnesses saying that when they called, the response was not adequate, and there is a need for an ombudsman or somebody to settle these things faster than just a prosecution. So basically you are that office. You are the first step, aren't you?

Would you define yourself as an ombudsman? Did you go over there? Do you call the people involved and say: What is going on? Do you have enough authority to do that?

Mr. MORRIS. No, Senator.

We are basically a criminal investigative agency at State level.

Senator PRESSLER. So you cannot do anything unless you think there is criminal activity?

Mr. MORRIS. That is correct.

We take the criminal complaint that comes from the agency that administers the Medicaid Program within the State of Florida. We take those complaints and we conduct a criminal investigation on this.

Senator PRESSLER. I am trying to get to the level of who.

Could we put something into the Clinton health care plan that would be like an ombudsman, that would be at a level where you are not criminally prosecuting? Could somebody go out there and look at it? Do we have that now in Medicare?

Mr. MORRIS. Not in Medicaid. I am not sure about Medicare. In Medicaid we do not have it.

Senator PRESSLER. What I am trying to get to is why do we have to wait until we have criminal evidence? Is anybody doing anything? Is there such an ombudsman now? Help me out.

Would that help? I don't know.

In other words, an ombudsman means somebody who is a troubleshooter and can go out and take a look at it and try to solve the problem. Kind of a—not like compulsory arbitration, but——

Would such a person help?

Mr. COFFEY. I think it is a fascinating concept.

The facility over them, you have got Medicare which is Medicaid, private sector, State and Federal. The person on the street does not have a clue which is which. It is very confusing. All you know when you think something rotten is happening with health care, who do you go to?

Some of your witnesses this morning actually know to call a particular office, but if you are a citizen in Dade County and you know that somebody is trying to sell you milk and you know it is wrong and you do not like it, who do you call?

Senator PRESSLER. You have to have intensification, dedication, and enough time to do it. Most people do not have that.

Then when you do call, you have to have the proof of a criminal case before something is really done?

Mr. MORRIS. From the standpoint of our office particularly at the moment, Senator.

Senator PRESSLER. My final question, Senator.

Would you assume if we expanded the Government's role in providing health care to our citizens, is it a fair assessment that probably this level of fraud would expand proportionately also?

Mr. HALLMARK. I am not going to say that I think it would expand.

I think I will just reiterate what I said earlier, and that is that you have a certain segment within any population, and that includes the health care provider operations, that is inclined toward defrauding the program, that are more interested in getting money than providing services. Those people will take advantage of whatever program is in place.

Senator GRAHAM. To follow up on a couple of Senator Pressler's questions, the comment was made I think by Ms. Gual that the first call you made you got a rather indifferent response. From the experience of you dealing with the concerns of your parents or those who use the senior center and these folks who represent law enforcement agencies, how could we put together a system that would deal as expeditiously as possible culminating in criminal prosecution if it was that bad, but using other resources? For instance, if you have a physician who is identified as having done some of the things, such as the psychiatrist did, somebody ought to contact the local medical association and say: You have got a member here who may require some professional discipline. Certainly you ought to contact the professional licensure board if you have a licensed physician who appears to be engaging in fraudulent activities.

Those are steps that can be taken, whether it rises to the level of criminal prosecution, that would help to stop this hemorrhaging of fraudulent activities.

Any recommendation as to less formal than criminal investigation and prosecution steps that might achieve an earlier result of stopping the bleeding?

Yes?

Dr. RODRIGUEZ. It would seem to me that if we are talking health care, health services, some medical professional, either a doctor or a registered somebody, has to sign for the services that are being paid for by Medicare and Medicaid.

Administratively and up front we could require, and I mean we, the people, could require that that person's name, title, or specialty, or entity, or whatever and license number appear on whatever bill is sent to Medicare. Therefore, you would assign responsibility, accountability to a person whose name, license, reputation would be at risk with every billing. That would require a profes-

sional or a business address, not a P.O. box—that would not be acceptable, period. So that people—beneficiaries and/or their advocates—could go into these offices and check and ask for documentation, it would help to challenge the claims, but before it is paid by Medicare. That would stop many providers from sending in false claims if they knew that their names and licenses were on the bill and they would be held accountable.

And then administratively, at the same phone number where we call for suspected fraud, have an administrator with authority, and I am not sure that I would want an ombudsman. I would want somebody with real authority that could call these people that were submitting the fraudulent claim or the suspected claim and say: Hey, this has been brought to our attention. We would like for you to check your documentation and send us a copy of your documentation because we are really looking at this in terms of considering taking action against you personally; you were the M.D. degree or the license used.

And that would stop many at that front end.

Senator GRAHAM. What about the concept that is used in some areas of civil law of multiple damages, like the triple damages that are utilized in the antitrust cases, directed at providers who submit fraudulent claims.

Mr. COFFEY. The False Claims Act provides for that in civil cases, so you can seek expanded damages.

One of the biggest single problems in so-called civil litigation though is simply dedication of resources to work certain cases. Traditional law enforcement proponents have a lot of limitations on their ability to prosecute civil cases. But I think to some extent that the remedies may be there in terms of triple damages and options like that.

It is a very important concept, Senator, because the civil cases have a lot of importance. They can be brought much faster. One of the things that frustrates the public is the length of time the criminal investigation takes. It has to take a long time. I am sure we all understand why they are as thorough and deliberate and meticulous as they are.

But a civil case can proceed sometimes in a matter of weeks. Literally some have been brought in a matter of days. They are more cost effective, and sometimes they are, frankly, more just, depending upon the circumstances of the defendant. We liken criminal indictment by the Federal Government to sort of the A bomb, and a civil case can be an intermediate weapon of great importance.

Senator GRAHAM. Yes, Ms. Gual?

Ms. GUAL. I believe that if we are going to have a law and criminal investigation, that we have to have very, very, very good agents. We also need other investigators so Medicare, instead of just paying the Medicare bill—like in my mother's case, they bill four times for the same month, and they pay all four times. Instead of doing that, why don't they send a questionnaire to the person? When they get a bill, send a questionnaire. When they disregard it, then send a card to the doctor's address, asking if some testing has been done, something so the patients could be informed that these charges are being made, because they get the statement, they get the charges, they pay, and then the patient gets the statement

and some of them do not even read it, because they know Medicare is paying so they don't read it.

If there was a mechanism where the patient gets, as soon as he gets Medicare he gets a bill and a letter to the patient saying, you know, asking them some questions about when did they see the doctor, the name of the doctor, the address, the telephone number of the doctor. Then you will know that it is a lie if they don't have that information.

They don't have that information because some of these places don't exist. They don't have an address. Try to go there. It doesn't make sense. It's not fair.

So I think if the patient gets informed before the payment is made—I mean, I don't understand why they don't have some kind of questionnaire that people might be answering. If they don't get an answer, they just can assume that the bill is wrong, that it is not a doctor's bill. You want Medicare to know that it is not a doctor, who has seen you.

I think this is something very basic. It is just going to be one question, and we can save millions of dollars.

Senator PRESSLER. I think these courageous witnesses here who have taken the time to do this should be commended. It seems to me, as I sit here, that we must do something about this in a dramatic way, if we are losing $1 in $5 of taxpayers' money, and this is going on. We must find some way that when your complaints go, that somebody deals with them short of a criminal prosecution, that there can be some kind of a—ombudsman may not be the right word, I am looking for a better word in English.

I think a design in Clinton's health care plan, or whatever it is going to be, we had better build in some safeguards so we do not have the same thing over, or the American people, the taxpayers, are going to be very disgusted with Congress. I always say, rather than blaming the agencies, a lot of responsibility is our fault. You know, Congress can do a lot of these things. We can pass laws. So I think there is a great burden on Congress in the next 3 months, not only to deal with this, but also to deal with the additional new Government programs we are putting into place. This hearing, if I may use what I heard here today during the debates on the health care plan, which we will be having, I guess, in July and September, as I understand it.

Thank you very much.

Dr. RODRIGUEZ. There is an appeal and a review process that is written into Medicare on the way that the billing is done. If the providers have a problem, they are taken care of expeditiously through that review process.

Now why isn't the consumer? Why isn't there a review process for the consumer?

It is in writing and it is in the Medicare regulation books for the benefit of the provider, but there is nothing for the protection of the consumer.

Senator PRESSLER. We are going to have to have something like that in the Clinton plan in this century.

Ms. GUAL. We should have a local office where people can come and complain about health care, where they can call and can visit or even the doctor here that knows of so many cases, they would

locally contact them. They should be able to inform and send them to the different places.

When people have problems with Medicare and Medicaid they want to express it, and they do not know where to go, or how to do it.

By doing something very simple, you know a simple system, where the person could go and fill out a form of what complaint they have; a statement that was sent to them for services they didn't need. For everything they get, you know, if they get a bill from Medicare, a statement from Medicare. If they know that they don't need these services, the elderly should be able to go somewhere or call somebody.

Senator PRESSLER. What you are saying is that an honest citizen who sees something wrong right now has a very hard time writing English. They will take your call maybe, but nothing happens.

Ms. GUAL. Because they are focusing on prosecution, and if you are building up a case and you do not want the doctor to know that you are building up a case, and these kind of cases are for $4 million in fraud. Meanwhile there are millions of dollars paid by Medicare. I have seen this. It comes out in the paper.

What we are saying is, let's not wait. Let's take care of the complaint at the complaint point.

Senator GRAHAM. We have some people in the audience who have asked to make statements.

One is Ms. Mattie Bethel, who is an AARP coordinator. Is Ms. Bethel still here? Ms. Bethel.

Ms. BETHEL. Yes.

Senator GRAHAM. Sir, if we could hear from Ms. Bethel first. You will be second. Is that OK?

But before I ask Ms. Bethel for her comments, let me ask Mr. Coffey a question.

There is a program which private attorneys essentially contract with the government on a contingency basis to pursue fraudulent cases. There is a word to describe that relationship, and the word escapes me at this point.

How effective has that relationship been in terms of pursuing Medicare fraud cases?

Mr. COFFEY. I do not think the answer is in for the private contracted programs.

Senator GRAHAM. What is the name of those?

Mr. COFFEY. I describe it as a private contract program. There are other terms for it.

Certainly somewhere they are actively studying it in terms of its effectiveness. I think at this point it would be hard to say. That is a major desirable option.

But I can certainly keep you informed on that sort of thing.

Senator GRAHAM. Thank you.

Ms. Bethel, would you like to speak now?

And then the gentleman will speak next.

Would you please give us your name and your organization?

MATTIE BETHEL, AARP CONGRESSIONAL COORDINATOR

Ms. BETHEL. Good morning, Senator Graham, and constituents.

My name is Mattie Bethel, and I am into quite a few organizations. I am the 17th congressional coordinator for AARP vote. I am on the eighth Human Rights Advocacy Committee. I was appointed by the Governor.

First and foremost, I am a community activist. I have been a community activist since in the late 1950's and early 1960's.

I wanted to talk to you all because of the present problems that are in the black community. I worked 11½ years for Dade County as an aide for them. What happened, I went from the Monroe County line to the Broward County line; all English-speaking people in public housing, and it is quite a few horror stories that's in those sections, especially at the senior citizens' buildings, in which we have a great number of elderly citizens in public housing.

I found out that quite a few HMO's would target those seniors, and I found it's two or three or maybe possibly more. They've come in and registered the people, and then when the people need medical assistance they couldn't get it, due to the fact that they would have one HMO this month. They would sign up for another one this month. And that is because those people did not know what they were signing.

This is something that needs to be addressed in this thing, because Medicaid and Medicare, this was one of the insurances that they have, and that's the only thing that they do have beside their little SSI or their Social Security. I found out there are clinics set up in the shopping centers and in store fronts all around Dade County and Monroe County as well; that they set up, they have people to come in. They pay them money for a one-time fee to have an examination in order to get their Medicare card number. Then from then on they just bill Medicare for the services that the people never receive. There should be some way that, if they are going to bill these people, there should be some way that the client could get a bill or something to make sure that they receive these services.

This is one of the things that I would like to see in there, because it is really going on, because there have been two or three people who died because they could not receive medical services when they needed it.

Thank you.

Senator GRAHAM. Senator Pressler.

Senator PRESSLER. From some points, this would just add a lot more paperwork to the system. How would you respond to that? If everybody had to fill out a form.

You mean you would have to fill out a form? Is that your proposal? They would have to fill out a form if they received the service.

Ms. BETHEL. They cannot receive the services due to the fact that these HMO's come in and they sign up for one this month, and you know it takes 30 days in order for them to have services. If they sign up with one this month and then they sign up with another one in the middle of the month, then they can't receive services from either one.

Senator PRESSLER. OK, I see the problem.

All right.

Senator GRAHAM. Do you think there are any particular problems in the African-American community as distinct from the general issues of Medicare fraud?

Ms. BETHEL. Yes; it is.

I know of some that's going on right now, where the people come, they pick these people up, and they go out and they solicit people to get signed up for Medicare and Medicaid in order to get their numbers, and then they pay them *x* amount of dollars. And then that's it.

And there is no way that—most of the people that they do this to, they can't read or write, and they are relying on what these people tell them.

Senator GRAHAM. That is the kind of situation where I think some early intervention——

You know most of those providers are licensed by someone. When you have a pattern of preying on people, as Ms. Bethel just described, they ought to have their license suspended while they are undergoing investigations for civil or criminal activity, but they should not be allowed to be out there like barracudas, continuing to pick on the unwary.

Ms. BETHEL. That's exactly what they are doing.

Senator GRAHAM. Thank you very much, Ms. Bethel.

Yes, sir? Would you please give us your name and your affiliation?

STATEMENT OF ERNY FANNATTO, PRESIDENT, $25,000 HOMESTEAD TAX

Mr. FANNATTO. Erny Fannatto is my name, and I am president of the $25,000 Homestead Tax, Dade County, State of Florida. I originated the homestead tax exemption bill. That was my bill in Tallahassee.

I see this here as an issue that is very important to all the people in the State of Florida and so forth. The elderly especially need it more than ever.

However, in order to get more attention you have got to increase the penalties. Once you increase the penalties you are going to get more action and less action against Medicare and Medicaid. We have got to do that, but you should have a special committee that gets to the newspapers, the newspapers, the health, the television, radio, so as all the people will see the severe penalty. Then they will think twice before they commit crimes. That is very, very important.

And I do want to say this here in conclusion: I want to thank you, Mr. Chairman, and your committee and everybody for coming here today. I know you are trying hard to do your best. But double up on your advertising and let all the people know that there is a severe penalty. Once they know that you will have less crime.

Thank you.

Senator GRAHAM. Thank you very much, Mr. Fannatto, and thank you for your long commitment to the important city causes in this community.

Mr. FANNATTO. Well, I appreciate that, sir.

Senator PRESSLER. Thank you.

Senator GRAHAM. Ms. Maria Christina Rodriguez.

STATEMENT OF MARIA CHRISTINA RODRIGUEZ

Ms. RODRIGUEZ. Thank you.

I am Maria Christina Rodriguez and I por favor came here——

My English is no good. I can speak in Spanish.

Senator GRAHAM. Mi Espanol es muy pobre, Maria.

Ms. RODRIGUEZ. OK.

Senator GRAHAM. Ms. Marisol Rodriguez will serve as an interpreter.

The INTERPRETER. She is representing the Little Havana's Activity Center. I just wanted to preface with that.

Ms. MARIA RODRIGUEZ [as interpreted by Ms. Marisol Rodriguez in English]. Martina Gonzalez is one of the people that goes to her place, which is like a nutrition center here in south Florida. She had a problem and she went to St. Judas Medical Corp. for callouses on her feet. When she went there, she got an EKG electrogram and she was given a blood analysis.

[Thereupon, Maria Rodriguez spoke further in Spanish and the following is the translation by Ms. Marisol Rodriguez:]

At the same time another company, Bass Orthopedic Lab, which she never went to, charged Medicare over $2,000 on the same day for a body jacket and two knee orthotics, and on the same day also charged them for two additional lower-limb orthotics.

She just wanted to let you know that she did not go for any of that.

Ms. MARIA RODRIGUEZ [speaking English]. The other person that came with me is for milk and two more companies bring the same service, that they don't know I never signed, I never know.

Senator GRAHAM. Dr. Rodriguez, are these some of the cases that you——

Dr. RODRIGUEZ. These are persons that are our participants at one or another of our 16 senior centers that get the services of our social workers. They come in with their bills, and they want to know what happened, and that is how we find out what is going on. At that point then the social worker will call the fraud hot line and initiate the reporting of what we know is happening.

So Maria Christina is talking about several of our participants. Some of them are with us today.

Senator GRAHAM. Ms. Rodriguez, do you know if the providers of those services, the podiatrist or the physician or others, are still practicing?

The Interpreter [translating to Maria Rodriguez in Spanish].

Ms. MARIA RODRIGUEZ. Yo creo que San Judas [continuing in English without benefit of the translator] is practicing now. I not be sure, but I think St. Judas Medical Corp. is now in function. The other I don't know.

Senator PRESSLER. Do you think that the people who cannot speak English well are taken advantage of more?

The Interpreter [translating to Maria Rodriguez].

Ms. MARIA RODRIGUEZ. Possibly.

[Through the interpreter]. It is possible that they are. They can't read the statements. They tell them one thing and then something else is done.

She said that there is like one company that fronts it and then she thinks that the Medicare numbers are given out, possibly sold to other companies that, therefore, they can claim on Medicare.

Senator GRAHAM. Are the materials that are sent to you written in English or Spanish or both?

Ms. MARIA RODRIGUEZ [without benefit of the interpreter]. Always English.

Senator GRAHAM. When you receive material from Medicare outlining what services have been allegedly billed to you, those statements are in English?

Ms. MARIA RODRIGUEZ [without benefit of interpreter]. Are in English.

The Interpreter [translating in Spanish to Maria Rodriguez].

Ms. MARIA RODRIGUEZ [without benefit of interpreter]. No; the Medicare never send nothing in Spanish, always it's in English.

Senator GRAHAM. Thank you very much, both Ms. Rodriguezes.

Ms. MARIA RODRIGUEZ. You are welcome.

Senator GRAHAM. Mr. Afterman.

AL AFTERMAN, GREY PANTHERS OF SOUTH DADE

Mr. AFTERMAN. Yes. Good morning, Senator. Thank you for conducting this hearing. I believe it is long overdue.

My name is Al Afterman. I represent the Grey Panthers of South Dade. It is an advocacy organization.

I think all we know about fraud, we heard more this morning than we have done in a long time, even though the Miami Herald occasionally exposes this.

It is my belief that no matter how many agents we are going to have to investigate, it is my belief that the community has to be involved in one form or another.

The question has been raised whether we should have an ombudsman or not. I think we, the older people, the recipients of Medicare and Medicaid, or even those who have not yet reached that point, we have a lot at stake. If one of five is defrauded, it means they are taking that much money from health care, that should go for health care. I believe that perhaps we should consider not only an ombudsman person, not to consist of a doctor, not to consist of a representative from the hospital, from the community, to serve as a clearinghouse where people can come and complain to, and they will be able to be referred to the proper agencies.

I think we should remember that the majority of the people who are defrauded are people who are either frail or have language problems or can easily be intimidated, and they are not any part of any organized community organization, like they are in the Little Havana that they have representation. They are to be found in neighborhoods, they are to be found in churches, they are to be found in isolation, and these people are not aware to what extent they are being defrauded. We have to find a way of reaching them.

Well, one of the two ways I may suggest is this: Perhaps under the Older Americans Act, their agency on aging should be authorized to establish a clearinghouse to listen to complaints, and they in return will make the proper referrals.

The ombudsman committee is they are going to nursing homes, should be authorized to investigate whether fraud is committed.

They should be able to refer patients or defrauded patients to the proper agencies.

And finally, I think, we are not aware of the existence of any agencies who are taking up the cudgels of the elderly in this relationship. There is not enough publicity, neither in English nor in Spanish or any other language. We are not aware that it was possible and who we can possibly go to complain to. There must be wide publicity in writing, publicity of the media. There must be publicity in every organization, every church that such agencies exist and if we are being defrauded we have a place to go to.

Until we have involvement of the community, on a voluntary basis if possible, and I know there are many, many people out there in the community who are willing and anxious to see that this fraud stops, unless that I believe we will not be able to resolve the problem.

Thank you.

Senator GRAHAM. Thank you very much, Mr. Afterman.

I want to thank all the members of the audience for your thoughtful attendance and participation here today, as well as our witnesses who have been extremely illuminating. I want to thank again those who represent families and individuals who have been victimized in Florida and who are sharing your personal stories and the recommendations that those have indicated might be helpful to avoid a repetition.

I want to commend all those who have represented agencies that have the front-line responsibility for ferreting out these instances of abuse in protecting the public against it.

And to my colleague, Senator Pressler, thank you for making the long trip from South Dakota to be with us today. Your participation has been extremely helpful, and I hope that together we can be a bipartisan effort to see that these issues are brought to the attention of our colleagues, and that action is taken to put a strong tourniquet around this very serious bleeding of the good will medical needs of many of our elderly, as well as the taxpayers of America.

Senator PRESSLER. Thank you, Senator. You have been a leader in this area, and our citizens in South Dakota and Florida and the Nation demand that we do something, something so that it does not repeat itself in the new health plan that will be adopted.

I thank you very much.

Senator GRAHAM. Thank you very much.

This has been an extremely illuminating hearing, and I can assure you that we are going to take action on the recommendations that we have heard today. We will continue to pursue this until we make the situation one in which we, as Americans, can take greater pride.

Thank you.

[Whereupon, at 11:15 a.m., the committee was adjourned, to reconvene at the call of the Chair.]

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ISBN 0-16-046588-5